MEDICARE+CHOICE: AN EXAMINATION OF THE RISK ADJUSTER

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

FEBRUARY 25, 1999

Serial No. 106–10

Printed for the use of the Committee on Commerce

U.S. GOVERNMENT PRINTING OFFICE
55–155CC WASHINGTON : 1999

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THURSDAY, FEBRUARY 25, 1999

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Stearns, Deal, Bilbray, Whitfield, Coburn, Lazio, Shadegg, Pickering, Bryant, Brown, Waxman, Green, Strickland, Barrett, and Eshoo.

Staff present: Tom Giles, majority counsel; Dan Boston, majority professional staff; Jason Lee, majority professional staff; Penn Crawford, legislative clerk; Bridgette Taylor, minority counsel; and Amy Droskoski, minority professional staff.

Mr. BILIRAKIS. The hearing will come to order. Good morning.

In the Balanced Budget Act of 1997, the Congress created the Medicare+Choice Program to provide Medicare beneficiaries with new choices of private health care plans. I supported those efforts because I believe that all seniors should be given the right to choose their own health coverage. Medicare+Choice offers new private health plan options to Medicare beneficiaries.

Seniors, as we know, may still select existing Medicare fee-for-service or they may now choose a Medicare+Choice health plan. In addition, a new payment method for health plans participating in the Medicare+Choice Plan was created by HCFA. This new payment methodology will be the focus of today's hearing. Prior to BBA 97, payments to Medicare managed care plans were based on the adjusted average per capita cost which we fondly always refer to as the AAPCC.

This was a monthly payment to Medicare risk HMO's that considered the cost of providing services to Medicare beneficiaries through the traditional Medicare program. However, HCFA and others were concerned that the AAPCC was an inaccurate representation of the true cost for HMO enrollees. Most studies indicate that healthier Medicare beneficiaries enroll in risk plans leading many to conclude that HMO's participating in the Medicare Program were receiving excessive AAPCC payments. Due to these valid concerns, BBA 97 mandated that HCFA implement a model which considered beneficiary health status when determining payment.

On January 15, 1995, HCFA announced the details of this new payment model, better known as a risk adjuster. The HHS Secretary is required to implement this risk adjustment methodology by January 1, 2000. In general terms, the risk adjustment considers a person's diagnosis in 1 year and predicts additional costs that the person will incur the following year. For example, an individual who has appendicitis 1 year, is not expected to have higher than average health costs the following year.

Therefore, such an encounter is not taken into consideration by the risk adjustment model. However, if someone has a stroke, above-average costs are predicted an a plan would receive a larger payment to cover the additional health care costs of this stroke patient. Currently Medicare pays health plans a fixed monthly payment for each beneficiary based largely on the fee-for-service, Medicare reimbursement for each county in the United States.

Risk adjustment adds diagnostic information to the payment calculation and significantly improves, we think, the accuracy of predicting expected costs. So overall this new system allows the market place to create new private health care options and provides beneficiaries with the information they need to make informed choices. For many, Medicare HMO's cover their deductibles, co-payments and other cost sharing, thus eliminating the need to purchase expensive Medigap insurance.

Most HMO's also provide beneficiaries, as we know, with extra benefits such as pharmaceutical drugs, eyeglasses, etcetera. The number of Medicare beneficiaries who enroll in HMO's has grown substantially with approximately 6.5 million enrollees in 1997. With the establishment of the Medicare+Choice Program this number is expected to grow even higher. I am pleased that the Administration has chosen to phase in the risk adjuster methodology in order to minimize any negative consequences to the plans.

Or even more important, to our Nation's seniors. Similarly, I am also pleased that HCFA has been flexible with health plans on many of the new BBA 97 compliance standards. For instance, HCFA's willingness to move the ACR date for this year from May 1, to July 1, was beneficial to both the plans and the beneficiaries. However, there are still many questions that must be addressed on HCFA's development of this new payment methodology. And of course we all are particularly interested in the real world impact on seniors and their health plans.

Over the past few months, a significant number of health plans have terminated our contracts with Medicare, upsetting the lives of more than 300,000 beneficiaries. In my home State of Florida, nearly 60,000 seniors have been impacted in more than 25 separate counties. I am deeply concerned about this matter, I think we all are. And want to work with HCFA, fellow Members of Congress and the health plans on a viable solution. And of course holding this hearing is the first step toward resolving this serious problem, we trust.

Over the next several months it will be critical for Congress, HCFA, beneficiaries and private plans to work together in a cooperative manner to make the Medicare+Choice Program work. Now having said this, I am sure the whole country knows by now that there is a bi-partisan Medicare Commission which may or may not

come up with a proposed solution to the long term care financing problems of Medicare. I am not sure whether I can say I am optimistic or pessimistic at this point.

A few days ago I was more optimistic than I am today. But I suppose that no matter what we might ultimately come up with if do, and certainly this Congress has to. If the Commission does not. In all probability the risk adjustment process will probably, will still be the one that will be in effect and I am sure that Mr. Hash will expand upon that. So I do want to conclude by welcoming our first witness, Mike Hash, the Deputy HCFA Administrator. Mike has testified before us before, but more importantly, I think he has provided distinguish service to this subcommittee for a number years on the issues of Medicare and health care reform.

And Michael, we look forward to your testimony. I know that your knowledge of the Medicare program will clarify the issues behind this complex risk adjustment model. Let us hear now, the ranking member and my very good friend, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Thank you for arranging today's hearing on risk adjustment. I would also like to thank Mike Hash, Bill Scanlon and the many other distinguished witnesses who have joined us today. Risk adjustment in Medicare is not an option, it is a necessity. Effective risk adjustment means more equitable payment across Choice+ Plans and the right distribution of payments between Choice+ and traditional Medicare.

The ultimate beneficiary is the Medicare enrollee. Proper risk adjustment promotes the right level of care for enrollees with different health needs. Just as proper risk adjustment strengthens the link between payments and costs, a risk adjustment mechanism that poorly predicts actual costs, weakens that link. Our discussion today will, I hope, shed light on the effectiveness of the proposed risk adjustment methodology, so that we can move forward toward a better calibrated payment system.

Risk adjustment is a quality issue, an equity issue and a fiscal issue. I am glad we will look more closely at that topic today. Thank you.

Mr. BILIRAKIS. And I thank the gentleman. Mr. Whitfield.

Mr. WHITFIELD. First, Mr. Chairman, thank you very much. All of us are quite anxious about this hearing today. It is obviously a very important subject. I have always been amazed at HCFA because it has been my experience as a layman that everything that HCFA does, and I don't mean to be critical, seems to be pretty archaic and byzantine to me. So when they come up with these new formulas, it is always quite enlightening.

And we recognize the importance of the risk adjusters because we want to provide incentives for plans to enroll the sickest patients and not disenroll them. So I think all of us are looking forward to the testimony that will be provided today and I yield back the balance of my time.

Mr. BILIRAKIS. And I thank the gentleman. Mr. Bryant, opening statement.

Mr. BRYANT. Thank you Mr. Chairman. My fellow members of the committee, good morning. I do want to welcome our guests and thank the witnesses who are appearing before us today. I appreciate you taking your time to be with us and certainly look forward

to hearing your testimony this morning. I am not alone in thinking that Medicare is one of the most important issues Congress will face this year.

We do owe to the millions of American seniors who depend on Medicare for health care expense, to make sure the program is solvent in the future and that it serves them well. We can all agree that protecting the financial stability is crucial. However, in addition to stabilizing the cost of Medicare, I believe it is also important to examine the effects, the changes Congress made in the Balanced Budget Act are having.

We must also examine the effects of HCFA's implementation of those changes and effects that it will have on private health plans participating in the Medicare+Choice. I want to be sure that the seniors in Tennessee and across America have choices when it comes to health care coverage. Now having said that, I have come to the hearing today with an open mind. I look forward to hearing the different parties represented here today and what you have to say with regard to Medicare+Choice risk adjuster. Thank you again, Mr. Chairman, and I yield back.

Mr. BILIRAKIS. I thank the gentleman. The gentleman from Ohio, I know you are just barely catching your breath, but you are more than welcome to make an opening statement.

Mr. STRICKLAND. Thank you. Thank you, Mr. Chairman. Recently Mr. Hash, there was a headline in the Dayton, Ohio paper that read, Seniors Ill Over Anthem Exit. Company losses are forcing it out of the HMO market in some counties. The article goes on to describe the story of a senior, Dodie Armstrong, who received her cancellation notice before her health care coverage membership even took effect.

Ms. Armstrong had gone to a meeting in April of last year to learn about Senior Advantage, the health maintenance organization that Anthem Blue Cross and Blue Shield was marketing aggressively to Medicare beneficiaries. The speaker at this meeting did not mention that Anthem had asked for Federal approval to withdraw Senior Advantage from Ms. Armstrong's community, yet they were still promotion their health care plan.

Even more troubling this incident was not an isolated one that was happening to seniors across the country. In my rural Ohio district, the median annual income for individuals over age 65 is $19,096. Given the high out-of-pocket health care costs born by senior citizens with chronic health problems, even with Medicare coverage, the HMO option is attractive to many southern Ohioans because it is affordable. These people simply cannot afford to incur additional costs of $1,000 to $2,000 a year in health care cost because their primary health care plan decides they are no longer a profitable market sector.

As we all know, the Balanced Budget Act of 1997, implements the risk adjustment formula to address the adverse selection issue. While many people have shown concerns over the quality of daily use to determine the formula and the actual short and long term implications of this approach, I believe risk adjusters begin to address a serious matter that needs to be resolved quickly. If I can just share one observation. A physician in Ohio has recently ex-

pressed concern that his older patients are extremely upset about the availability or lack of it, of affordable health care.

He believes that as a result of this uncertainty, he will begin to see more seniors with anxiety, depression, chest pains and other problems triggered by stress. Even for those seniors who can still manage to cover their health care costs without the HMO, the money spent on health care takes away from money otherwise budgeted for groceries, electricity and rent. For a vulnerable population stress, which has a very significant influence on overall health, could become a life-threatening matter. The time is right for us to pursue options that make it more likely that managed care entities will not only make but will honor commitments to the most vulnerable among us.

I am eager to work toward redirecting the focus of HMO's away from profit motives and toward the focus of providing quality, affordable health care to everyone. And I believe that risk adjusters just may be the first step that will enable them to do so. Having said that, I look forward to hearing from you. Thank you.

Mr. BILIRAKIS. The gentleman from Texas, Mr. Green, for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman. And I want to thank you for calling the hearing this morning because this is the first hearing this session on what I consider one of the more important issues. Not in Medicare, the global issue, but also in Medicare+Choice it was created to give more options and more beneficiaries more health care options. Particularly many seniors chose Medicare HMO's because of the additional benefits, especially the prescription drug benefit.

In a recent survey of drug costs in my own district showed that seniors without any prescription drug benefit were paying almost double what HMO's and other preferred customers pay. Unfortunately the Medicare+Choice Program seems to be, at best, falling well short of our goals. Hundreds of thousands of seniors live in areas that are not served by HMO's and many more were dropped from their HMO when they decided, when it was decided Medicare simply wasn't profitable enough to continue covering those seniors.

Of course that statement lies in direct contrast to what a recent GAO Report says that the Medicare HMO on the average are still being paid, being overpaid because they typically recruit and serve healthier seniors. And that is why a full implementation of the risk care adjuster is important. It is the only way to make sure that HMO's are paid for what they do and who they serve. If a specific HMO wants to only cover healthy patients, then they should only be paid as much as that HMO, as an HMO that is willing to provide to care to sicker patients.

However, the recent withdrawal of so many HMO's from the Medicare Program raises legitimate questions on whether these HMO's are being overpaid by Medicare or if in their minds they are not just being overpaid enough. I look forward to hearing from our distinguished witnesses today and I thank you for being here. Mr. Chairman, I yield back my time.

Mr. BILIRAKIS. Mr. Waxman, no opening statement?

Mr. WAXMAN. I will pass.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. JOHN SHADEGG, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. Chairman, I commend you for holding this hearing. Medicare+Choice is a program which is significant to many of the people who are over-65 and reside in and around my district, Phoenix. Changes which are made to this program, be they to beneficiaries directly or to plans and their operations, are important to my constituents. Given the expectation that the number of people in Arizona aged 65 and over will grow by 34% between 1998 and 2010, effects of changes to the Medicare+Choice program are particularly significant.

Let me restate the importance of the Medicare+Choice program in Arizona: Arizona has 10 Medicare HMOs, and Medicare enrollment in these "risk HMOs" as a percentage of total beneficiaries is 39%. *This is almost three times the national average* of 15%. Changes to this program affects nearly a quarter-million people in Arizona.

For the past few years, a great deal of attention has been given to the need to reform Medicare, improving its solvency and making it operate in a more efficient manner. While the President has proposed setting aside 15% of surplus to "save" Medicare, I am skeptical of his ideas. Also, we need to think and act in a way to make Medicare run in a more efficient manner. And, we have done that, in the Balanced Budget Act of 1997 with the proposal to more properly risk adjust payments to Medicare HMOs.

It is for this reason that I support the concept which passed in the Balanced Budget Act of 1997—to find a better methodology for the payment of Medicare HMOs and prevent overpayment of these companies relative to the risk and expenses incurred by enrollees using their services. We need to find ways to improve incentives for plans to provide high quality health care services, but also to seek out ever greater cost savings to be passed on to Medicare, and ultimately, taxpayers.

Let me also say that I support other proposals to improve the efficiency of Medicare. Phoenix has recently been chosen as a test site for the Competitive Pricing Demonstration Project, to improve the setting of Medicare+Choice reimbursement rates.

I commend HCFA for phasing in these changes over a 5 year period and recognize that Congress may have tied HCFA's hands with respect to only collecting hospital encounter data for use in this program. However, I have significant concerns about the implementation of the methodology which HCFA has recently proposed. In its proposal, HCFA has chosen a route which only uses outpatient encounter data in the fifth and final year of the transition period, rather than phasing it in sooner, not later.

I want to highlight how this program may impact non-hospital programs such as long term care facilities and other providers that *focus on keeping the elderly out of hospitals.* EverCare is a skilled nursing facility which presently operates a successful demonstration program nationally, which includes sites in Phoenix. As a result of using only hospital encounter data and not phasing in the use of outpatient data, EverCare may face the prospect of closing down its facilities after 2000. Under Medicare+Choice rules, also, if EverCare closes its facilities, it will not be able to re-enter a market for 5 years. Certainly, having companies like EverCare leave the Medicare+Choice program and forcing its residents to look elsewhere will be an outcome that benefits no one.

During this hearing I look forward to hearing from HCFA and its plans to improve the transition to the risk adjustment methodology, especially from 2000 to 2001 How will it begin to use outpatient data? I also look forward to hearing from the health plans and beneficiaries who will be affected by this program.

Thank you and I yield back the balance of my time.

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Thank you, Mr. Chairman.

I am pleased that the Health and Environment Subcommittee is holding this hearing today. The Medicare+Choice program stands as one of Congress' most significant achievements.

Prior to the Balanced Budget Act of 1997, America's seniors were faced with an ailing Medicare program. Just as troubling, Medicare was a program that offered its beneficiaries little freedom to obtain truly responsive and effective coverage.

The Medicare+Choice program changed all that. The explicit intent of this program is to give seniors access to more choices than ever before, so that they can get better coverage than ever before.

That is why it is so vitally important that Congress ensure that the risk adjustment model developed by HCFA for the Medicare+Choice program meets not only the letter of the law, but also the spirit in which Congress intended these changes in plan payments. I am pleased that the Administration has chosen to phase-in this new payment methodology to minimize any potential negative consequences to the plans.

Similarly, I am also pleased that HCFA is showing greater flexibility in helping plans meet many of the new BBA '97 compliance standards. For instance, their willingness to move the ACR date for this year from May 1 to July 1, is good for both the plans and the beneficiaries.

As we will hear today, early efforts by HCFA to write Medicare+Choice regulations have been widely viewed as too onerous and prescriptive. Last Fall, a number of insurance providers dropped out of the market. We cannot let this pattern repeat itself.

I am pleased that the Agency is taking steps to rewrite portions of these regulations. And I would encourage them to continue doing so.

This Committee takes a dim view of regulations that exceed their statutory basis. That is why I hope we will continue this series of formal inquiries by this Committee into this important program and its implementation.

Again, Mr. Chairman, thank you for convening this hearing today.

Mr. BILIRAKIS. Thank you, I would appreciate that. The opening statements, of course, of all members of the subcommittee are, without objection, made a part of the record. Mr. Hash, I am going to set the clock for 10 minutes. Obviously your written statements are part of the record, please share your knowledge with us.

STATEMENT OF MICHAEL HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. HASH. Thank you, Mr. Chairman. Congressman Brown, distinguished members of the subcommittee, I want to thank you for this opportunity to come and discuss our efforts to pay Medicare+Choice Plans accurately and fairly. The Balanced Budget Act, as has been pointed out here this morning, requires Medicare risk adjust payments starting January 1, 2000. That means we must base our payments to plans on the health status of their enrollees.

We believe this is a vast improvement over the current payment method. Risk adjustment will increase payment to plans for their sickest enrollees, and thus curtail what many have perceived as the disincentives to enroll these beneficiaries. It will also lower payments for healthier enrollees of managed care plans. Risk adjustment is an essential component of the Medicare+Choice Program.

We want to thank, at the outset here, the health plans who are contracting with Medicare, for their cooperation in providing the data that is essential and needed for this important advancement in payment policy. And we want to continue working with plans to resolve any remaining data issues. The law requires us to begin risk adjustment, as I said, on January 1, 2000. However, we believe we must proceed in an incremental and prudent fashion.

So we have decided to phase in the risk adjustment over a 5-year period to prevent disruptions to beneficiaries or to the Medicare+Choice Program and health care plans. In the first year, only 10 percent of the payment to health plans will be based on this new risk adjustment. First we must base the risk adjustment on in-patient data alone, that is where we are starting. But by 2004, we will be using data on all health care encounters including

out-patient services, physician office visits and so forth to implement a comprehensive risk adjustment.

Later this year we will be issuing a schedule for health plans and the methods for reporting this wider base of encounter data that I referred to. If we could base risk adjustment on more comprehensive health care data now, we would. But that cannot be done at this time. But even with that limitation, we believe that risk adjustment, based on in-patient data alone, will increases the accuracy of our payments to Medicare+Choice Plans by five-fold.

Plans themselves have raised concerns about risk adjustment based on in-patient data alone, suggesting that it could create perverse incentives for unnecessary hospitalizations. We therefore have taken a number of steps in designing our payment and risk adjustment to prevent inappropriate hospital admissions or attempts to inflate data submitted for use in risk adjustment payments.

It is essential to stress, I think that risk adjustment will not and cannot be budget neutral. The whole reason for proceeding with risk adjustment is that the Medicare Program has not been paying plans accurately and properly. There is substantial evidence, which you will be hearing about in the course of today's testimonies, that we overpay plans because payments are not now currently adjusted for the health care status or expected health care costs of enrollees in managed care plans.

Studies by the Physician Payment Review Commission, PPRC, now MedPAC, the Congressional Budget Office, Mathematica Policy Research and many others, have all found that Medicare has been paying far too much because plans tend to enroll healthier, low-cost beneficiaries. If risk adjustment were budget-neutral, Medicare and the Taxpayers who fund it, would continue to lose billions of dollars of each year on managed care payment.

Accurate risk adjustments inevitably and appropriately must change aggregate payments to managed care plans. Actual savings will vary according to the extent that less healthy beneficiaries enroll in Medicare+Choice Plans. Risk adjustment significantly changes the incentives and could well lead to the enrollment of beneficiaries with greater health care needs and that could lead to higher payments for health plans who enroll such individuals.

Overall we project that payment to plans on average in the year 2000, will change by less than 1 percent of total managed care payments. Phasing in the risk adjust also substantially buffers the plans from any financial impact that they are likely to experience. Without a transition, Medicare savings for a full risk adjustment or without a phase in would have been $1.4 billion or more in the first year, in the year 2000. And as much as $4.5 billion over the full 5 years.

We will closely monitor the impact of the risk adjustment on beneficiaries and plans and continue to work with them to refine and improve this methodology. But clearly we believe we must start now. Mr. Chairman, I want to thank you for this opportunity to come before you and to talk about this important change in the way we pay Medicare health plans that are serving our beneficiaries.

I look forward to responding to any questions that you or other members of the subcommittee may have. Thank you very much.

[The prepared statement of Michael Hash follows:]

PREPARED STATEMENT OF MIKE HASH, DEPUTY ADMINISTRATOR, HCFA

Chairman Bilirakis, Congressman Brown, distinguished committee members, thank you for inviting me here to discuss our efforts to pay health plans accurately and fairly. The Balanced Budget Act of 1997 requires Medicare to "risk adjust" payments to Medicare+Choice organizations, starting January 1, 2000. That means we must base payment to Medicare+Choice plans on the health status of their enrollees.

Risk adjustment is an essential component of the Medicare+Choice program, and represents a vast improvement over the current payment method. It helps assure that payments are appropriate and curtail the disincentive for plans to enroll sicker beneficiaries.

Under risk adjustment, data on individual beneficiaries use of health care services in a given year will be used to adjust payment for each beneficiary enrolled in a Medicare+Choice plan the following year. The payment adjustments are based on the average total cost of care for individuals who had the same diagnoses in the previous year. In order to prevent disruptions to beneficiaries and health plans, we will phase this change in over five years. Initially, we will use data on inpatient hospital stays and move in an orderly fashion, as envisioned in the Balanced Budget Act, to use of data from other health care settings.

We would like to thank plans for their cooperation in providing the data needed to implement this important advance.

Currently, some 6 million of Medicare's 40 million beneficiaries have chosen to enroll in Medicare+Choice plans. Risk adjustment will increase payment to plans for their sickest patients, and thus curtail the disincentive for plans to enroll these beneficiaries. It also will lower payment to plans for their healthier patients. Risk adjustment is an essential step forward for beneficiaries, taxpayers, and health plans.

- *Risk adjustment will help beneficiaries* feel confident in all their Medicare+Choice options. It will assure beneficiaries that Medicare pays plans the right amount to provide all necessary care because payment to plans will take each enrollee's health status into account. That will help people with serious illnesses, such as cancer or cardiovascular disease, who can benefit most from the coordination of care health plans can provide.
- *Risk adjustment will help taxpayers* by addressing the main reason that Medicare has lost rather than saved money on managed care. Many studies show that health plans enroll Medicare beneficiaries who, on average, are much healthier and therefore less costly than those who remain in traditional Medicare. This "favorable selection" of healthy beneficiaries has cost taxpayers $2 billion a year, according to a 1997 report by Congress' Physician Payment Review Commission (now part of the Medicare Payment Advisory Commission).
- *Risk adjustment will help level the playing field* among Medicare+Choice plans. It will temper the risk of significant financial loss when plans enroll beneficiaries who have expensive care needs, and focus competition more on managing care than on avoiding risk. Risk adjustment also will help plans by alleviating concerns among beneficiaries that plans have financial incentives to deny care.

Phasing-In Risk Adjustment

The law requires us to proceed with risk adjustment starting January 1, 2000, and does not call for a transition. However, we believe we must implement these changes in an incremental and prudent fashion, as was done with other new major payment systems. We are, therefore, using flexibility afforded to us in the law to phase in risk adjustment over 5 years to prevent disruptions to beneficiaries or the Medicare+Choice program.

In the first year, only 10 percent of payment to plans for each beneficiary will be calculated based on the new risk adjustment method based on inpatient hospital diagnoses. The remaining 90 percent will be based on the existing method for calculating plan payments, which are flat amounts per enrollee per month based on the average cost to care for Medicare fee-for-service beneficiaries in each county and adjusted for basic demographic factors like age and sex. In 2001, 30 percent of payment amounts will be risk adjusted. In 2002, 55 percent of payment amounts will be based on risk adjustment. In 2003, 80 percent of payment amounts will be based

on risk adjustment. By 2004, we and health plans will be ready to use data from all sites of care, not just inpatient hospital information, for risk adjustment. Then, and only then, will payment to plans be 100 percent based on risk adjustment.

Using Inpatient Data

During the first year of data collection for risk adjustment, both the statute and practical issues require that we use hospital inpatient data alone. About one in every five Medicare beneficiaries is hospitalized in a given year. Data on these hospitalizations are relatively easy to gather, easy to audit, and highly predictive of future health care costs. We will use the data to pay plans more for beneficiaries hospitalized the previous year for conditions that are strongly correlated with higher subsequent health care costs. While we will eventually be using a broader data base for risk adjustment, that is simply not feasible at this time.

The Balanced Budget Act clearly stipulated that more comprehensive data on outpatient, physician, and other services could be collected only for services provided on or after July 1, 1998. That was prudent, because it has been no small task for plans to learn how to gather the inpatient data we are using for the initial phase-in of risk adjustment. Requiring plans to provide additional data on outpatient, physician and other services would have been unduly burdensome at this time.

This year, we will issue a schedule and guidance to plans for reporting other encounter data, such as outpatient information. The schedule will provide sufficient time for plans to gather accurate data and for HCFA to analyze and incorporate the data into accurate risk adjusted payments. We are now confident that by 2004 we will be using data on all health care encounters to assess beneficiary health status for risk adjustment. If we could base risk adjustment on more comprehensive data now, we would. But we cannot. The law requires us to move forward. And, even with its limitations, this initial risk adjustment system based on inpatient data alone will increase payment accuracy 5-fold.

The initial risk adjustment system uses only the approximately 60 percent of inpatient hospital diagnoses that are reliably associated with future increased costs. For example, beneficiaries hospitalized for conditions such as heart attacks in aggregate are at higher risk of subsequent cardiovascular problems, and they consistently have higher health care costs in the subsequent year. Hospitalizations for such diagnoses will lead to higher payments to plans in the following year under risk adjustment. Hospitalizations for acute conditions such as appendicitis, however, rarely lead to increased subsequent care costs. They will not lead to higher payments under risk adjustment.

The 60 percent of hospital admission diagnoses that are clearly associated with increased subsequent care costs account for about 30 percent of all Medicare spending the following year. It is important to note that, while risk adjustment is initially based only on inpatient data, the risk adjustment payments account for all costs of care associated with each diagnosis. It is also important to note that risk adjustment is not cost-based reimbursement; it is reimbursement adjusted for projected need based on health status in the previous year.

Determining Diagnosis Groups

The relevant diagnoses will be used to classify beneficiaries into 15 different cost categories. One category is for beneficiaries who were not hospitalized the previous year with relevant diagnoses. For beneficiaries included in any of the other categories, plans will receive an additional payment to cover the increased risk associated with diagnoses in that category.

Payment will continue to be adjusted for demographic factors, such as age, gender, county of residence, and whether a Medicare beneficiary is also a Medicaid beneficiary. We have revised these demographic factors for use with risk adjustment, for example, by no longer including institutional status because the risk adjustment methodology itself does a good job of predicting expenses for nursing home residents.

Medicare will calculate a score for each beneficiary to determine the payment that will be made if they choose to enroll in a Medicare+Choice plan. For example, Medicare's average payment per year to health plans is $5,800. Under risk adjustment, payment for an 85-year-old man will on average be $6,414. It will be an additional $2,060 if he is on Medicaid, another $1,207 if he is disabled, and $8,474 more if he was admitted to the hospital for a stroke the previous year, for a total of $18,155. The score for each beneficiary will be calculated annually, and will follow them if they move from one health plan to another.

Protecting Program Integrity

Most health plans operate with integrity and play by the rules, and we doubt that plans will compromise successful medical management programs that keep patients

out of the hospital in order to game the risk adjustment system. However, plans themselves have raised concerns that risk adjustment based on inpatient data alone could create perverse incentives for unnecessary hospitalizations. We, therefore, have taken solid steps to prevent gaming of the system with inappropriate hospital admissions or attempts to inflate the data submitted for use in risk adjustment.

The risk adjustment system does not include hospital stays of just one day, in order to help guard against inappropriate admissions. And it excludes diagnoses that are vague, ambiguous, or rarely the principal reason for hospital admission. In addition, we will use independent experts to assess the validity and completeness of data plans submit to us by conducting targeted medical record reviews and site visits. This will help ensure that plans do not "upcode," or claim that hospital admissions were for more serious conditions that would result in higher payment.

Protecting Taxpayers

It is essential to stress that risk adjustment will not and cannot be budget neutral if we intend to protect the Medicare Trust Fund and be fair to the taxpayers who support our programs. The whole reason for proceeding with risk adjustment—and specifically with risk adjustment that is not budget neutral—is that Medicare has not been paying plans properly.

There is considerable evidence that we have overpaid plans and continue to overpay plans, in large part because payments are not adjusted for risk.

- The Physician Payment Review Commission, in its 1997 Annual Report to Congress, estimated that Medicare has been making up to $2 billion a year in excess payments to managed care plans. This Congressional advisory body notes that, unlike the private sector where managed care has slowed health care cost growth, managed care has increased Medicare program outlays. The Commission's 1996 Report found that those who enroll in managed care tend to be healthy and those who disenroll tend to be unhealthy, exacerbating Medicare losses.
- Mathematica Policy Research, which has conducted several studies on Medicare HMOs, says care of Medicare beneficiaries in HMOs costs only 85 percent as much as care for those who remain in traditional fee-for-service Medicare. That is 10 percent less than the 95 percent of the average fee-for-service costs plans were being paid.
- The Congressional Budget Office has said managed care plans could offer Medicare benefits for 87 percent of Medicare fee-for-service costs, even though they were paid 95 percent.

Congress also recognized that plans have been paid too little for enrollees with costly conditions, and too much for those with minimal care needs. The simple demographic adjustments made now for age, gender, county of residence, Medicaid and institutional status, do not begin to accurately account for the wide variation in patient care costs. Risk adjustment will.

The vast majority of beneficiaries enrolled in Medicare+Choice cost far less than what Medicare pays plans for each enrollee. Medicare fee-for-service statistics make clear why risk adjustment must not be budget neutral. More than half of all Medicare fee-for-service beneficiaries cost less than $500 per year, while less than 5 percent of fee-for-service beneficiaries cost more than $25,000 per year, according to the latest available statistics for calendar year 1996. The most costly 5 percent account for more than half of all Medicare fee-for-service spending.

Since Medicare+Choice enrollees tend to be healthier than fee-for-service Medicare beneficiaries, the ratio of high to low cost beneficiaries in health plans is even more stark. Clearly, care for the overwhelming majority of Medicare enrollees costs plans much less than what Medicare pays because our payments are predicated on the average beneficiary cost of care, calculated by county. This average includes the most expensive beneficiaries in fee-for-service, who generally do not enroll in managed care.

If risk adjustment was budget neutral, Medicare and the taxpayers who fund it would continue to lose billions of dollars each year on Medicare+Choice. Accurate risk adjustment inevitably and appropriately must change aggregate payment to plans.

Budget neutral risk adjustment would cost taxpayers an estimated $200 million in the first year of the phase-in, and $11.2 billion over 5 years if health plans maintained their current, mostly healthy mix of beneficiaries. It is important to stress that actual savings to taxpayers from risk adjustment will vary to the extent that less healthy beneficiaries enroll in Medicare+Choice plans, resulting in higher payments than health plans receive today.

The amount of payment change will vary among plans and depend on each plan's individual enrollees. Total payment may be higher for some plans as they enroll a

mix of beneficiaries that is more representative of the entire Medicare population. As part of our Medicare+Choice March 1 rate announcement, we will send a letter to each health plan with an estimate of how payment will differ from what they are paid now, based on their current mix of enrollees.

Overall, we project that payment to Medicare+Choice plans on average will change by less than one percent in the first year. How it will change over time depends on the mix of beneficiaries in each plan. Risk adjustment significantly changes incentives for plans and could well lead to enrollment of beneficiaries with greater care needs. That could result in plans receiving higher payments than they do now. Phasing in risk adjustment also substantially buffers the financial impact on plans. The federal government is forgoing $1.4 billion in savings in the first year and as much as $4.5 billion over the full 5 years because of the phase in.

Payment changes will be further buffered by an annual payment update for 2000 that our preliminary estimate suggests will be 5.2 percent. This is substantially larger than projections that were made last year. The final figure will be released March 1, 1999. This annual update is based on formulas set in law and projected expenditures for Medicare that are included in the President's fiscal year 2000 budget.

CONCLUSION

Risk adjustment is an essential step forward for Medicare, beneficiaries, taxpayers and the Medicare+Choice program. It will help Medicare pay plans fairly and accurately. It will curtail disincentives to enroll less healthy beneficiaries. It will help taxpayers and the Medicare Trust Fund start saving, rather than losing, money on managed care. It will help level the playing field among plans. And it is required by law.

We are aware of the magnitude of the impact of risk adjustment and are, therefore, phasing in implementation to avoid undue disruptions. We are also taking proactive steps to prevent potential gaming of the system. We will closely monitor the impact on beneficiaries and plans. We will continue to consult with beneficiary groups, health plans and academic experts. Adjustments can be made each year as we proceed.

But, clearly, we must proceed. Risk adjustment is too important to postpone and too important to implement without a prudent phase-in that allows time for any necessary refinements. Again, I thank you for inviting us here today to discuss this, and I am happy to answer your questions.

Mr. BILIRAKIS. Thank you, Mr. Hash. Well, let me ask you a question that is in the general, generic, category. And without maybe oversimplifying the problem, it seems to me that many of these managed care companies which are choosing not to continue in the Medicare beneficiary area, are doing so mainly on the come, so to speak. Or doing so because the risk adjustment is coming and they don't like what they see coming and what their obligations or responsibilities are going to be.

Many of them have already told us they look upon the regulations as being too onerous in addition to the other responsibilities that go along with it. What is your response to that?

Mr. HASH. Mr. Chairman, we think that the risk adjustment methodology that we are going to phase in is actually a needed improvement to the management of the program. We think it is what the Congress intended when it enacted the Balanced Budget Act. We have spent a lot of time over the last year working with plans, with other experts, with the Academy of Actuaries, with a whole host of folks to actually design an appropriate and implementable risk adjustment methodology and we think we have done that or are about to do that.

And we don't think that it would be appropriate to delay the progress on bringing payments more in line with the expected cost of the beneficiaries who choose to enroll in managed care plans. The imbalance between what we are paying and the costs of the

enrollees has been documented in study after study. And I think if for no other reason, our fiduciary responsibility to the program means that we should move ahead and make sure these payments are accurate rather than continue with the significant overpayments that we have experienced.

Mr. BILIRAKIS. Well are beneficiaries being dropped, because programs or plans are pulling out of certain areas. I took a look at a chart here somewhere and there are more beneficiaries impacted by this in Florida, for instance. That concerns you, does it not?

Mr. HASH. It does.

Mr. BILIRAKIS. All right. Now what, if that concerns you, how is HCFA planning to meet that concern? I mean, we have heard the opening statements up here and we have heard a lot of complaints on the AAPCC process. And risk adjustment appears to be, certainly make a lot more sense. I think roughly everybody seems to think it is a good idea. But in the meantime, we have these problems.

We have these beneficiaries who basically have lost their choice. They certainly could go back to fee-for-service, but they have lost their choice. How will you respond to that and how is HCFA planning to respond to that? What are you plans and your strategy in that regard?

Mr. HASH. Mr. Chairman, since the experience of last fall that you and other members heard a lot about when plans decided not to participate or at least to reduce the geographical areas that they were going to participate in, we have been working with the plans and with folks in the Congress, your staff as well, to analyze exactly what the reasons were for that non-participation. And you may know, that last month, we published a regulation, an interim final regulation, that addressed a number of concerns that plans had raised about the regulations we published last summer, last June, to implement the Medicare+Choice Program.

We think we have actually gone a significant way toward addressing the issues that plans identified as the reason for, at least some of the reasons for, dropping out. I think it is important to recognize that there are a host of factors that influence a decision by a health plan to withdraw from participation in Medicare. One of the things I think that struck me as most interesting about the experience last fall was that as we look back on it, we determined that about an equal percentage of health plans that had been participating in the Federal employees health benefit program also dropped out of that program or chose not to participate for Federal employees this coming year in some of the same markets that the Medicare+Choice Plans withdrew from.

Presumably in addition to payment concerns, health plans look at market situations, the penetration of their own plan, the competitive nature of the markets in which they are engaged. There are a whole host of factors, only one of which presumably is Medicare payment and Medicare requirements. And we tried to address some of the concerns that have been raised since last fall.

Mr. BILIRAKIS. So, in other words, you feel that many of, or at least some of the clients' decisions to withdraw aren't necessarily directly related to the proposed risk adjustment plan?

Mr. HASH. I believe that to be the case, Mr. Chairman.

Mr. BILIRAKIS. All right. Let me ask you, were you or a member or one of your representatives going to remain throughout the entire——

Mr. HASH. Yes sir, yes sir.

Mr. BILIRAKIS. [continuing] and take notes?

Mr. HASH. Yes sir.

Mr. BILIRAKIS. Because we have a lot of the insurance representatives testifying later on.

Mr. HASH. Yes sir.

Mr. BILIRAKIS. Thank you very much. Mr. Brown to inquire.

Mr. BROWN. Thank you, Mr. Chairman. Mr. Hash, thank you for your very informative testimony. Clearly part of the problem is we don't have enough information from many of these Medicare HMO's so we can make some of these decisions, but last, as you know, some 400,000 people nationally have been dropped from their Medicare HMO. United Health has dropped some 50,000. In my home county of Lorraine, Ohio they dropped 2,000 people without appropriate notice. People read it in the newspaper and began to call offices like mine and others.

But in counties nearby, Cuyahoga, Medina County, other counties, they didn't drop people. I know because we don't have all the information, so perhaps you can't answer this. But if we had had a risk adjustment system like the one discussed today, would this likely have happened?

Mr. HASH. Well, I think it is hard to say, as I said a moment ago. There are many factors that go into the calculation about whether to participate and which markets to participate in. To say that if we had a full comprehensive risk adjustment in place, would that have reduced the extent to which plans pulled out? I think in some cases it probably would have. For plans who felt like they had above-average health cost enrollees, more adequate payments for the needs of those enrollees would have obviously helped to ameliorate their financial concerns about continuing to participate. But I am not sure that would be the case in all plans. And the risk adjustment benefit depends on the nature of the kinds of individuals, in terms of their expected health care costs, that are actually enrolled in the plan.

So, you know, for plans who withdrew because they felt like they had a non-representative group of enrollees in the sense that their health care costs were higher on average than the typical Medicare beneficiary, those people would have been helped by a full risk adjustment.

Mr. BROWN. You had said that you don't have, you can't use comprehensive data to develop the risk adjuster. Is that because you are not getting that data from HMO's? You can't gather the data or you haven't had time to process it and put a comprehensive amount of data together to do it? What is the problem?

Mr. HASH. It is some of all of that, Mr. Brown. Risk adjustment for plans and for us represents a new stage of our relationship. We have not traditionally, in our contracts with managed care plans, required them to report to us the clinical data on hospitalizations or encounter data on out-patient services or clinic services. That has not been a part of what they have been doing. So what we have been trying to do is to build the data infrastructure.

We started with, as the Congress said in the BBA, collecting inpatient hospital data. That is what we did beginning January 1, 1998. We are going to put in place the tools and the formats for plans to report this broader array of data, but we think it takes time. We want to work with the plans and give them the time to do this. We want to prepare ourselves to make sure we can receive that data properly. And that is why we have phased in the risk adjustment in the way we have.

Mr. BROWN. One final question. Congressman Stark has sent some testimony to this committee, which in a moment I will ask the chairman to enter into the record. In his testimony, he noted that a letter from the HCFA Administrator describes a "little known glitch in the Balanced Budget Act that overpays HMO's $8 billion over 5 years and $31 billion over 10 years." The HCFA Administrator ascribes this overpayment to a lower rate of medical inflation.

Would a risk adjustment have dealt with this, so that this overpayment would not have happened? Or if it would not have, is there a way of doing risk adjustment and somehow roll this hedge against inflation or really a reverse of that into it?

Mr. HASH. I think what happened, Mr. Brown, was we estimated the updates that are required for updating the rates paid to managed care plans. And in the base year that now forms the basis for rates for managed care plans, 1997, the statute in the BBA did not included authority for us to correct any errors in that projection.

And as we look back on the estimates we made from 1997, we determined that the overstatement was about 4 percent of what it should have been in terms of the update to the rates. And we lack the authority to correct what was built in, and that is, I think, what Mr. Stark is referring to as built in and above inflation to the rates. This would not actually be affected by the risk adjustment methodology that we are talking about. It is a separate but important issue.

Mr. BROWN. And can we deal with that.

Mr. HASH. I don't think actually that is——

Mr. BROWN. So that it is——

Mr. HASH. [continuing] that is a problem that can be dealt with by the risk adjustment language. I think we would be happy to work with you and others to see other avenues for dealing with it. But I don't think it can be dealt with through risk adjustment.

Mr. BROWN. Mr. Chairman, I would like to ask your honor's consent to enter into the record Mr. Stark's testimony?

Mr. BILIRAKIS. Without objection.

Mr. BROWN. Thank you, Mr. Chairman.

[The prepared statement of Hon. Pete Stark follows:]

PREPARED STATEMENT OF HON. PETE STARK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, Members of the Committee: Congratulations on holding this hearing on this important issue. I would like to make three short points.

1) On behalf of the HMOs that have done the right thing and enrolled a fair and representative proportion of the Medicare population—both the sick and the well—*I urge that Congress not consider legislation delaying the phase-in of the risk adjustor.* Any delay will reward those who have avoided the sick and chronically ill, and punish those who have sicker than average patients—and that is exactly the opposite of good health policy.

By phasing in the risk adjustment, we have already hurt the best HMOs, and given the industry a $4.7 billion gift (see attached table).

2) Second, *we should not buy the argument of the for-profit HMOs that we are not paying them enough*. I would like to enter into the Record a summary of the ways we have been overpaying Medicare HMOs. I would also like to enter a letter from the HCFA Administrator that describes *a little known 'glitch' in the Balanced Budget Act that overpays HMOs $8 billion over five years, and $31 billion over ten years.* This overpayment occurs because we took away the authority of HCFA to adjust for overpayments in 1997. We paid plans a higher amount in 1997 than was justified in light of the lower medical inflation which actually occurred. By allowing these overpayments, we built into the budget base billions of dollars in extra payments. As the Administrator's letter makes clear, *the other budget savings in the BBA do not even correct for this mistake—let alone reduce the earlier, underlying overpayment to the Plans.*

3) Most importantly, *the testimony today of the fourth panel of private sector plans shows—indeed proves—why the Premium Support plan being pushed by a majority of the Bipartisan Commission on the Future of Medicare will not work*

The President of PacifiCare Health Systems is testifying:

> "Unless Congress [delays risk adjustment/gives us more money] the number of providers who refuse to contract with Medicare+Choice plans will increase, and health plan withdrawals will continue at a more rapid pace."

The Vice President of Blue Cross and Blue Shield of Florida is testifying:

> "that HCFA's current approach [to risk adjust] will ultimately cause health plans to exit the program or significantly reduce benefits . . ."

On behalf of the Health Insurance Association of America, the Senior Vice President of CNA Health Partners is testifying:

> "If the current reimbursement structure is not adjusted [i.e., pay us more money] more Medicare+Choice organizations are likely to withdraw from areas served and beneficiaries enrolled in the remaining plans will likely experience premium increases or reduced benefits."

And the Vice President of Humana testifies:

> "Some plans have already decided to discontinue participation in the M+C program in one or more counties . . . it is likely more plans will go this route in the next two years if the . . . risk adjustment system is implemented on the current schedule."

In short, pay us more or we can't offer extra benefits—in fact, we may not even be able to stay in the program.

But as described in my second point above, we currently pay Medicare HMOs more than we should. We pay the plans more for the people they enroll than we would have paid if those people had stayed in Medicare Fee-For-Service. The taxpayer would actually save money if we abolished the Medicare+Choice program.

Unfortunately, the beneficiaries in these plans who have been getting extra benefits will lose, and that is why *we need to improve the core Medicare program, so that everyone has a drug benefit and catastrophic protection—and so that people do not need to join an HMO to get extra benefits.*

The Bipartisan Commission on the Future of Medicare's majority is pushing the idea that we can save Medicare hundreds of billions of dollars—as much as $475-$850 billion in the year 2030—if we can only get more people to enroll in private plans. (They have no proof of this savings; they just assume—*assume*—that private plans will grow 1% per year less than Medicare fee-for-service over the next thirty years. They assume this although the history of the last 11 years shows Medicare and Premium Support growing at almost exactly the same rate—the FEHBP Premium Support model grew only 0.1% less than Medicare, not 1.0% less!)

But if plans say they cannot offer extra benefits at a time when we are overpaying them, they certainly won't be able to when Medicare actually starts saving money by paying them more accurately for the people they enroll.

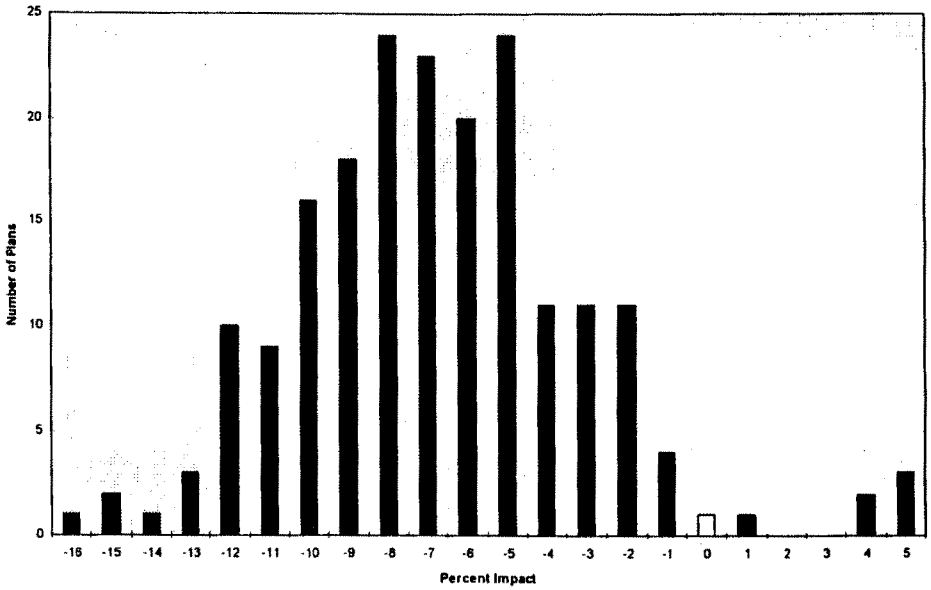
And if the plans can't offer extra benefits, who in the world would want to join a system that rationed their choices and services?

Premium Support won't work to save Medicare—it is just a way to raise premiums on seniors and the disabled to force them into bare-bones, no-frills HMOs that will offer no extra benefits. Indeed, more than half of all the savings projected for the Breaux-Thomas Premium Support plan would come from higher payments by beneficiaries.

I hope all the Members will consider the testimony of Panel 4 before they endorse the Premium Support scheme.

The representatives of the managed care plans testifying today are, in fact, testifying that the Breaux-Thomas Premium Support plan will not work.

Preliminary Impacts of Risk Adjustment, Shown Without a Transition
Because of the transition, and the 2% minimum update, it is estimated that no plan will receive a reduction in total payments relative to 1999.
(Based on data received through 11/16/98)



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

FEB - 1 1999

The Honorable Pete Stark
House of Representatives
Washington, D.C. 20510-6200

Dear Mr. Stark:

Thank you for your letter regarding the American Association of Health Plans (AAHP) concerns about the Medicare+Choice (M+C) program and their Adjusted Community Rate (ACR) proposals. I regret the delay in this response.

The AAHP asked the Health Care Financing Administration (HCFA) to allow plans to revise their ACR proposals. I informed AAHP by letter on October 1, 1998, that, given the late date for the request, we would not allow such broad revisions to the approved ACR proposals because many beneficiaries would receive fewer benefits, while paying more for their health care. We concluded it would not be in the best interest of beneficiaries, nor administratively feasible for HCFA, to reopen the premium and benefit calculations for virtually all Medicare managed care plans.

HCFA's only divergence from this position occurred in early November 1998, when we allowed health maintenance organizations in Massachusetts a brief, time-limited opportunity to resubmit the prescription drug portion of the previously approved 1999 ACR. This proposal applied to coverage and premiums related only to prescription drugs. Plans were not allowed to change their service areas or any of the other benefits for enrollees. HCFA wanted to do everything possible to work with the Massachusetts' plans in order to minimize any confusion resulting from a conflict between Federal and state laws. We believe this opportunity to address the prescription drug benefit is the best solution.

It is true, as indicated in your letter, that the 1997 rates which are the mandated base for the Balanced Budget Act of 1997 (BBA) payment methodology, are overstated by 3 percent. The BBA mandated reductions to the updates for M+C rates through 2002, and some have argued that these reductions were meant to adjust rates for favorable selection. However, the savings from the reductions, once they are fully implemented, do not even equal the increased costs due to the overstatement. While the BBA provided authority for making adjustments to updates for over and under estimates, no authority was provided to adjust the base rates.

I hope this information is helpful.

Sincerely,

Nancy-Ann DeParle

Nancy-Ann Min DeParle
Administrator

Phase-In

Calendar Year	Blend Percentages	Overpayment Reduced under Phase-In	Overpayment Reduced without Phase-In	Savings Forgone Due to Phase-In
2000	90% demographic/ 10% PIP-DCG	0.2b	1.6b	1.4b
2001	70% demographic/ 30% PIP-DCG	0.7	2.6	1.9
2002	45% demographic/ 55% PIP-DCG	1.5	2.4	0.9
2003	20% demographic/ 80% PIP-DCG	2.5	3.0	0.5
2004	100% risk adjustment	6.3	6.3	0
	Total	**11.2**	**15.9**	**4.7**

CURRENT MEDICARE OVERPAYMENTS TO MANAGED CARE PLANS
(prepared by Rep. Pete Stark's staff)

SOURCE OF OVERPAYMENT	COST TO MEDICARE	SOURCE OF ANALYSIS
Overpayments due to BBA change that removed HCFA's ability to recover overpayments when health care inflation is lower than expected.	$800 million in 1997 $8.7 billion over 5 years $31 billion over 10 years	Congressional Budget Office
Overpayments due to lack of risk adjustment.	5-6% overpayment to HMOs per beneficiary who is enrolled	Physician Payment Review Commission (now MedPAC) 1996 Annual Report
Overpayments due to inflation of Medicare's share of plan administrative costs.	More than $1 billion annually	HHS Office of Inspector General July 1998
Overpayments due to inclusion of fraud, waste and abuse dollars from FFS payments. Managed care plans should better "manage" and therefore avoid such fraud, waste and abuse.	7% annual overpayment Annual savings with a corrected 1997 base year would be: $5 billion in 2002 $10 billion in 2007	HHS Office of Inspector General Sept. 11, 1998

Mr. BILIRAKIS. Mr. Whitfield.

Mr. WHITFIELD. Mr. Hash, I had noticed that a lot of these payments are going to be based upon a diagnostic cost grouping. And under the existing payment system, I think, to hospitals there are, and I am not sure I have this correct, but there are DRG groupings.

Mr. HASH. That is correct.

Mr. WHITFIELD. Now are they the same as this diagnostic group?

Mr. HASH. They are not, Mr. Whitfield. What we have done in the risk adjustment, is to identify what amounts to approximately 12 percent of all hospital admissions. We have indicated that for enrollees that have an admission that falls into one of those categories, about 15 categories altogether, that will be an individual for which a larger payment will be forthcoming to the plan.

The hospital in-patient DRG System is one which involves something like 480 or so separate DRG's to cover the full array of conditions that might occasion someone to be hospitalized.

Mr. WHITFIELD. Okay so the, I noticed in the diagnostic groups, there are 172 of those and so that is totally separate then from the other, okay. And could you just briefly explain the way you are going to use the diagnostic cost groups in determining the factor that would be applied to patients?

Mr. HASH. Yes it is, the first step is to identify a subset of hospital admissions that are associated with high cost, both the probability of future hospitalizations, as well as in many cases, extensive outpatient care that is required. And, having identified people who have a hospital admission in one of those categories that is associated with significant increased health care costs, then those individuals will be assigned a risk score, if you will, higher than the average. This will translate into a payment on their behalf that will be higher than the average payment the plan would otherwise receive.

Mr. WHITFIELD. Okay. Okay, Mr. Chairman, I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Mr. Strickland.

Mr. STRICKLAND. Thank you, Mr. Chairman. Mr. Hash, given the experience that some of my constituents have had in regard to losing coverage that they thought they had and could depend upon, I just want your personal opinion, if you would be willing to offer it. Do you think that HMO's that market just seniors should have an obligation, as a part of their marketing strategies, to provide a disclaimer indicating to the seniors that this coverage may not be there for them in the future. So that they can make whatever choices they make with, after being fully informed as to what they may face?

Mr. HASH. That is a difficult question, Mr. Strickland. I would have to say, from the marketing point of view, such a disclaimer in marketing materials, I think, would be viewed as a significant impediment to the enrollment of Medicare seniors. On the other hand, I recognize that the fact that plans can voluntarily come and go in the Medicare Program. Actually, as you might know, if plans withdraw from the Medicare+Choice Program from now on, they are banned from coming back in the program for 5 years.

So there is, how should we say, a much stronger disincentive for a plan that is currently participating in the program to withdraw if they expect to come back into the program any time in the near future. So I think some of the ability of plans to come and go on an annual basis, will be reduced by that protection in the BBA. And one of the things we do require, we have a lot of requirements related to the marketing materials, that plans reach out to senior citizens.

And one of the requirements associated with marketing is that they must disclose that they can terminate coverage. In other words, they tell the beneficiaries that if they give them proper notice, that the plan may in fact withdraw from participation in the Medicare Program. So that is actually part of the notice requirements that we impose in terms of the marketing materials that they use.

Mr. STRICKLAND. Well apparently for many that, that information is not either being given or being recognized because so many of my constituents made decisions in good faith, they gave up Medigap coverage, they have pre-existing health care conditions and then at a moment in time, they find that they do not have the coverage that they, I mean that is what, I have always thought that is what insurance is. Something that you can depend on.

If you can't depend upon it, then it is not insurance, it is something else. And it just, it really troubles me that so many of our most vulnerable citizens feel as if they have been manipulated or misled and I was just wondering if there was something we could do to make that less likely to happen in the future?

Mr. HASH. Well, I think I should point out why I think it is less likely in the future. Last year was unique in the sense that it was something of a transition year. Plans operating under the old system had the opportunity to give a notice 90 days before the end of the year, October 1, that they would not be participating in the new calendar year.

That has now changed under the BBA and plans have to indicate to us earlier in the year about their commitment to be in, so that when beneficiaries have a chance to make a choice in November of each year. Plans will then be locked in for the coming year and there won't be this last minute kind of withdrawal from the program that we experienced last year. So I think the potential is much less in the future.

Mr. STRICKLAND. Okay, and if I can ask one more quick question. As a result of Mr. Waxman's suggestion, I had a study done in my district regarding prescription drug prices. And what we found was that seniors who participate in HMO plans, that the drugs available to them are much cheaper than seniors who are not a part of such a plan. The differential on five drugs was 107 percent. And I am wondering, as you do this risk adjustment, if you factor in the fact that HMO's on average get much, much less costly drugs than do non-HMO participating seniors?

Mr. HASH. I think the answer to that is a complicated one, Mr. Strickland. But the brief answer would be, you know, that Medicare does not cover much in the way of drugs to begin with, so that wouldn't be reflected in our payments to managed care plans. With respect to the drugs that we do cover under Medicare, which are

basically drugs often that are provided as part of an in-patient hospital stay, the cost of those drugs are reflected in the rates in the sense that the way we cover them under the fee-for-service system.

They are built in there, but they are probably built in at a level that is higher than the acquisition costs on the part of HMO's, because many HMO's obtain discounts and have group purchasing arrangements that provide, as you point out, more favorable drug prices. And that data is not fully reflected in the rates that we pay.

Mr. STRICKLAND. And it seems as if some cost shifting may be taking place from the HMO participant to the non-participating senior.

Mr. HASH. Yes.

Mr. STRICKLAND. Thank you, Mr. Chairman, I am sorry I went over.

Mr. BILIRAKIS. No problem. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Mr. Hash, I have three questions for you and I will one at a time, of course. The health care plans have expressed concerns that it is difficult for them to validate or replicate your risk adjustment calculations because HCFA has not provided them with the formulas used for the components of the risk adjustment methodology. This lack of complete information makes it difficult, if not impossible, for the health organizations to forecast revenues.

Will this information be provided to health plans and if so, when?

Mr. HASH. Mr. Bryant, we want to work with the plans to resolve any questions about data that is not available to them, because I have heard the same sort of comments. Let me just say, as I indicated earlier, beginning last September, September 8 to be exact, we published for comment the model, the risk adjustment model and methodology that we were going to use. We got lots of comments from health plans and others.

We submitted it to the American Academy of Actuaries, who have also reviewed and analyzed it. We met with the health plans in the fall over this. On January 15, we sent a notice to all health plans which indicated what the methodology was and provided information about the average risk scores that were being determined. On March 1, next week, we will be communicating with every plan giving them information about their specific risk adjustment for the enrollees that they currently have.

They can use that information to prepare their submissions to us later in the year about the benefits and premiums they are going to charge. We will be giving them the software that we used to group the patients into these various risk cells. We think we have been very forthcoming, very transparent. To the extent there are issues that plans feel that we have not given them, we would like to talk to them about that.

We would be happy to try to work with them. But we think we have been very forthcoming on the data front.

Mr. BRYANT. Thank you. And I know we will certainly hear from some of those folks later on in this hearing. Earlier you have made arguments that health plans have been overpaid for providing health care services and that the risk adjustment method is needed to correct this overpayment. However, the health care organiza-

tions maintain that the data used to make this judgment is old data from 1992, in fact.

Number one, I guess, is that a correct statement that it is from 1992? And number two, how can you state with certainty that plans are currently overpaying using data from 7 years ago?

Mr. HASH. Mr. Bryant, I would say that there are a variety of studies out there that have looked at the issue of the adequacy of payments, proper payments to managed care plans. Some of those studies go back as far as you are talking about. One as recently as 1997, by the Physician Payment Review Commission indicated that they felt in the aggregate we were overpaying managed care plans by $2 billion a year.

The General Accounting Office, which will be testifying following me, has also done studies based on more recent information. So I think actually there is a considerable amount of evidence of current vintage that suggests that we are overpaying health plans.

Mr. BRYANT. Again, my final question. You alluded to some of this information in your statement, I wish you would expand on that. In terms of the transition, the concerns that the first 4 years of, we haven't finished the first 4 years of the 5 year phase in, concern only in-patient hospital data that would be used to predict future patient cost. Further, only hospital stays of 2 days or longer will be included in the methodology.

I guess what we are looking for is more reasoning for this and also that, as you said, there might be some perverse incentive involved here that would have health care providers admit beneficiaries who keep in the hospital longer to work this in. Again, could you simply expand on why this was chosen?

Mr. HASH. Well, the first answer is, to your question, is that we used in-patient data because the BBA laid out a schedule that said we were to start collecting only in-patient hospital data, January 1, 1998, and to use that for the first part of the risk adjustment beginning in the year 2000. That is the short answer for why we are using in-patient data.

On the issue of whether our methodology creates an incentive for inappropriate hospitalizations, I think what we have done in designing our methodology is to carve out from the admissions that we are going to treat ones that are warranting a special payment, discretionary admissions, admissions for conditions that are not associated, you know, with future health care.

For example, someone who has an appendectomy who may have a very short hospital stay, that would be an admission which we would not count as predictive of increased future costs.

Mr. BRYANT. When will you do this? Because again, I think our whole——

Mr. HASH. That is——

Mr. BRYANT. [continuing] our whole purpose is to——

Mr. HASH. That is actually a part of the risk methodology that we will be implementing next January.

Mr. BRYANT. But can you get these encounters, these other medical encounters, for the 4 years?

Mr. HASH. We are going to start collecting that data. We are going to put out a schedule later this year and we will, our present

plan is, to implement the full risk adjuster based on the more comprehensive data in 2004.

Mr. BRYANT. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. And Mr. Hash, the plans that have withdrawn from the Medicare Program over the last 6 months claim to be losing money, however the GAO recently reported that even after the Balanced Budget Act, Medicare still overpaid some of the plans. Were the plans that withdrew actually losing money or were they not earning as much as they expected?

Mr. HASH. I actually have not been able to review the financial conditions of the plans that withdrew, so I wouldn't be in a position to comment on their profitability or lack thereof. Clearly in some of their statements about their reasons, they indicated that Medicare was no longer profitable to them.

Mr. GREEN. The risk adjustment is critical in preventing the cherry picking of healthy beneficiaries and, but is it possible that the basic payment levels are too low to meet the needs of seniors?

Mr. HASH. There has been a lot of talk about that, Mr. Green. And I think the answer to that is that it depends on what part of the country you are talking about, what kind of area. The BBA, as you know, went a long way to try to narrow the range of payments that Medicare makes to managed care plans by bringing up the floor. It is now about $380 per person in the lowest areas.

And it also put in a blending methodology which in the first 2 years, 1998 and 1999, we were not able to actually implement because of budget neutrality limitations. But the newest data for the year 2000, in terms of the update for managed care rates, indicates that there will be about a 5.1 percent increase in managed care rates. The effect of that will be to fund the blended rates in the large number of counties around the country.

What that means is, for counties that are below the average, by blending with the average, their rates will be brought up. So we think that in lower payment areas, beginning in the year 2000, there will be some additional help in terms of the adequacy of the payment rates that are available for Medicare beneficiaries in private plans.

Mr. GREEN. And why wasn't out-patient data included?

Mr. HASH. Well, because under the way the BBA laid out the requirement to move to risk adjustment, it required us to start collecting in-patient hospital data on or after January 1, 1998. That is what we have done. We will be allowed to collect a broader array of data, including the out-patient data and that is what we will use for the comprehensive risk adjustment that will be put into effect in 2004.

Mr. BILIRAKIS. Thank you, Mr. Green. Thank you, gentleman. The vice chairman of the subcommittee, Dr. Coburn.

Mr. COBURN. Mr. Hash, good to see you again. Thank you, and let me just remind you I am still waiting for some of that information on nursing homes.

Mr. HASH. Yes, actually Dr. Coburn, I signed the letter this morning.

Mr. COBURN. Great, thanks. Do you feel comfortable that you really have——

Mr. HASH. And one to you, Mr. Chairman, as well.

Mr. COBURN. Do you feel comfortable that you really have the data right now, enough data based on what the experience is out there, to put forward a risk adjuster?

Mr. HASH. Dr. Coburn, we do. We have collected data on over 1.2 million admissions between the period July 1, 1997, through June 30, 1998, for 5.5 million beneficiaries and we actually think we have a very rich data base.

Mr. COBURN. And geographically distributed properly as well?

Mr. HASH. Yes, sir.

Mr. COBURN. Okay. I am interested in what Mr. Brown gave us in terms of adjusting and I would be anxious to talk with you in terms of trying to do the authority to get the adjustments made in terms of that growth. Would it be possible for HCFA to develop comparisons, say like from 1990 to the present to give the members on the committee sort of a historical perspective on the number of renewals and non-renewals on Medicare managed care?

In other words, we are seeing this big abrupt withdrawal now, but how does that compare to historical changes and renewals and non-renewals?

Mr. HASH. Last year was definitely much higher than any previous experience. I think I am correct and my colleagues will probably correct me here. For the years 1994, 1995 and 1996, we had a total of 5 health plans that completely withdrew or reduced service areas. And obviously we had a much larger number last year, 99 either withdrew completely or reduced their geographical service area. So last year was, by any means, much higher than any previous experience.

And in fact plans have been generally increasing in 1999, I am told, to correct it here a little bit. In the mid-'80's we had a very large drop of plans who dropped out of the program. I will get you the specific data on that.

[The following was received for the record:]

Medicare Plan Renewals/Non-renewals 1985-1998

Year	Total Risk Contracts	Non-renewals	Renewals	Percentage Non-renewing
1985	87	3	84	
1986	149	7	142	5
1987	161	29	132	18
1988	154	34	120	22
1989	131	38	93	29
1990	96	14	82	15
1991	93	12	81	13
1992	96	8	88	8
1993	110	4	106	4
1994	148	1	147	1
1995	181	0	181	0
1996	241	2	239	1
1997	307	8	299	3
1998	346	45	301	13

Source: Medicare Managed Care Contract Plans Monthly Summary Reports.
Non-renewal rates peaked in 1988 and 1989.
The percentage of nonrenewals in 1998 was 14 versus 22 in 1988.
Prepared by the Office of Legislation, HCFA, March 1999.

Mr. COBURN. I think it would be real helpful for the members to see it in terms of perspective. You know as you look at all this, firms are going to either participate or not participate on this on whether they can make any money in it. I mean that is what they are in the business for. As you sit and look at that, how much money should they make?

Mr. HASH. Well, I think again it is difficult to answer that precisely. I think the purpose of this risk adjustment methodology is to try to say, with the payment policy we have now, we are clearly not paying appropriately and that we need to change that and to bring the payments more in line with the expected costs that enrollees are going to experience. And if that means that people have lower than average costs, who are enrolled in managed care plans, that is going to be a lower payment for them.

But for those who have sicker patients, it is going to be a higher payment for them and we think that is an appropriate change.

Mr. COBURN. So could these firms expect in the future that now the risk adjustment is out there and things are going along and can they expect a crunch again? In other words, all of a sudden we move more people into managed care and the costs rise a little faster than what they were and things start going up and they creep a little bit. Are we going to come back through HCFA and say, well you know, our risk adjuster is a little too high, we are growing a little faster than what we thought too. And we are going to tighten that up.

Because ultimately that is what it counts on. And I am interested in your perspective, because I know you all understand that if they don't make any money, they won't be, I mean they may on the short term. And I am not saying they are not making any money. There was a wonderful report on PacifiCare that happened to time with this hearing that is enlightening. But the point is at some point we have to decide, with your help, how much is a good rate of return for people who are offering this service?

Mr. HASH. I agree with that, Dr. Coburn. I mean we do have to monitor very carefully participation by plans and the reasons they are giving for the inadequacy of our payments, where that exists. And pay attention to that. Because if we want choices for Medicare beneficiaries we are going to have to pay adequately for it. I just don't have a ready answer to tell you what sort of changes might be needed.

But one of the reasons we are phasing in this risk adjustment is to not further destabilize the market for these plans and to minimize the changes of payments that will happen to plans. So that at least in the short run, we shore up the market place for our beneficiaries.

Mr. COBURN. Well is it your feeling, I know you may not be able to have the knowledge on this. Is it your feeling that we had the tremendous withdrawals in this because of the lack of a certain expectation coming? And that because there was a lack of an expectation of a fixed amount or an unknown out there in terms of being able to predict what they were going to be able to do, we saw more withdrawal than what we would have otherwise?

Mr. HASH. I think the anticipatory effects played a large role. I think people were uncertain at the point they made their decision

about what the risk adjustment would be over time. I think they were uncertain about the rate of increase in plan payments over time in the aggregate. And that uncertainty certainly played a role in the decision of many plans, I am sure, to withdraw.

Mr. COBURN. Thank you.

Mr. BILIRAKIS. Mr. Waxman to inquire.

Mr. WAXMAN. Thank you, Mr. Chairman. Mr. Hash, if we don't have an adequate risk adjuster, it seems to me we are encouraging plans to try to skim and get the healthiest population in order to make more money. Then we overpay them because we pay them based on the amount that Medicare paid for the average population. If we can't get a risk adjuster, we are overpaying them. Isn't that what we are faced with and why this committee and the Congress asked you to develop a risk adjustment?

Mr. HASH. That is correct, Mr. Waxman.

Mr. WAXMAN. We don't want to overpay. We don't want to give an incentive for plans to try to refuse the sicker patients and only go after the healthier patients. But it is not easy doing a risk adjuster, is it?

Mr. HASH. No, sir, it is not. It is very complicated.

Mr. WAXMAN. It is very complicated, but it is very necessary. But let me just go beyond where we are today. There is a Medicare Commission that is now looking at changing the Medicare Program. And if we don't have a good, accurate risk adjuster under the premium support system, which is what they are talking about over there, what we are going to have, it seems to me, is a system where people who go into a fee-for-service system are going to find it unaffordable because they are going to have to pay more money. Isn't that the case? And why would that be the case, if it is?

Mr. HASH. It is the case. Well, I think there are several issues there. But a premium support program, as I understand it, could not function without a risk adjustment methodology. It just would not work. And I think members of the Commission, Mr. Bilirakis, who is a member of the Commission, have been through lots of discussions about that. So I think that is one of the reasons for what we are doing here. If it turned out there were some kind of premium support approach introduced into Medicare, experience with this risk adjustment is absolutely essential to making that——

Mr. WAXMAN. When you say it wouldn't work. It would work——

Mr. HASH. Well——

Mr. WAXMAN. [continuing] it would produce some results that we wouldn't find very satisfying.

Mr. HASH. Correct.

Mr. WAXMAN. I mean after all if you pay a percent of the average of the premiums for all plans, including fee-for-service, and you don't have any risk adjustment, if a plan is able to make a lot of money and pay a lower amount because they have skimmed off a healthier population, then they are going to drag down that average of all the plans.

And then, as a senior, when you want to go into a plan that has a higher premium and costs more money, the government says, oh, this is all we are going to give you for that. You are going to have to come up with the difference because you are going into a plan that is going to have a disproportionate amount of sicker patients,

it's premium is higher, you get paid proportionately less for it. Isn't that the fear we would have?

Mr. HASH. That is correct. If you don't have a risk adjustment you are going to have significant adverse selection in the model that you just described. And the affect of adverse selection is obviously that the plans who get the sicker individuals will have increasingly higher costs, higher premiums. And the individuals who choose those kinds of plans, will have to pay more for them.

Mr. WAXMAN. Well it seems to me the stakes get higher and higher. We better make sure we have some risk adjuster that works, especially if we are even looking at a drastic, radical change of the Medicare Program as is being discussed by this Commission. We are having a tough enough time now, under the Medicare+Choice Plan to make sure that we get a risk adjustment that works.

Let me ask you about the prescription drug issue. The President has said we ought to cover prescription drugs under Medicare. Some people are saying we ought to cover prescription drugs under Medicare only if people go into a managed care plan. What would be your view of a system like that?

Mr. HASH. Well, I think the President has been very direct on that point, Mr. Waxman. And his view and the view of the Administration is clearly that prescription drugs are a needed addition to the Medicare Benefit Package and that they should be provided across-the-board in the traditional fee-for-service program, as well as any private managed care plans.

Mr. WAXMAN. Well wouldn't some want to push people into managed care? Isn't that mainly what people think we want to do? I mean if we stack the deck without a risk adjuster and we cover drugs only under managed care, aren't we telling people, you don't really have a Medicare choice, you have a choice between a bunch of managed care plans?

Mr. HASH. That certainly is one way to look at it, Mr. Waxman. I think what we are trying to ensure is that we don't have a situation where there are markers for plans that create adverse selection. Which gets to the same point you are making, which is if only some plans offered prescription drugs to a senior and disabled population, they are going to inordinately attract, I think, a large number of those beneficiaries into those plans.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. COBURN. Yes sir, would you yield for one question for Mr. Hash.

Mr. BILIRAKIS. Without objection, you can have an additional 30 seconds.

Mr. WAXMAN. Thirty seconds, okay.

Mr. COBURN. I just want to complement your political savvy. I mean we are already debating something that isn't out there yet and it is really important. I really respect that because you are already setting the markers of where you don't want the Commission to go, which I praise you for. I think that is good. It is also very smart politically. My question was——

Mr. WAXMAN. How about on policy grounds?

Mr. COBURN. No, I think it is better on political grounds than it is policy. My question is——

Mr. WAXMAN. Are you ready to make the leap?

Mr. COBURN. Not with Mr. Waxman, it is not. Mr. Hash, the average paid on HMO yearly, versus the average consumed by non-HMO Medicare, could you give us those two numbers?

Mr. HASH. I think the average payment for a Medicare+Choice Organization is about $475. And the annual amount on the fee-for-service side I think is more like $5,000 or so a year, but I am quickly dividing that to make it comparable to the $475, would be——

Mr. COBURN. It is about $5,500?

Mr. HASH. Yes, roughly.

Mr. COBURN. So in essence, right now today, managed care is $500 more?

Mr. HASH. No, that is the annual amount per capita for Medicare, about $5,500.

Mr. COBURN. And what is it on managed care?

Mr. HASH. It would be 475 times 12.

Mr. COBURN. Well, that is about $5,700.

Mr. HASH. Yeah.

Mr. COBURN. So it is comparable. Okay, thank you. And I thank the gentleman for yielding.

Mr. BILIRAKIS. Mr. Deal to inquire.

Mr. DEAL. Thank you, Mr. Hash. With the risk adjustment factor going in, are we still operating under the 95 percent cap?

Mr. HASH. You mean, I think you mean that we pay 95 percent of the average fee-for-service costs.

Mr. DEAL. Is that still a limiting factor on the top side?

Mr. HASH. Yes, sir, it is.

Mr. DEAL. How do you deal with that if in fact the risk adjustment has the exact opposite effect of what we say managed care has now. That is, is there going to be an incentive to select those who are sicker because the risk adjustment in effect pays more. If that occurs, how does the 95 percent figure into the mix? Are they going to be penalized if they have a higher number of sicker patients as opposed to what the situation is now? How does that fit?

Mr. HASH. Well, the 95 percent in effect, gets you to what we would say would be the base rate for managed care plans. And what the risk adjustment does is to say, for that small subset of enrollees who have these hospital episodes that fall into one of these 15 categories, that the base rate will be increased by an amount that roughly approximates what the data show are the expected health care expenditures in the following year for an individual who has such a hospital episode.

So I think, you know, the way those two things work together is that 95 percent just gets you to the base rate that we actually pay. The risk adjustment methodology identifies a subset of all the people who get the base rate and gives them an additional premium associated with their expected health care costs for the coming year.

Mr. DEAL. Okay. Will the assessment be made on an annual basis, a per patient annual basis?

Mr. HASH. It will be.

Mr. DEAL. And it is prospective, in other words.

Mr. HASH. It is.

Mr. DEAL. You assess their situation in 1999, which would affect their rate reimbursement for the year 2000?

Mr. HASH. That is correct.

Mr. DEAL. Are there any interim adjustments based on catastrophic illness, etcetera?

Mr. HASH. Well, the way the methodology works is that we are actually basing the next year's adjustment on the experience in the year that is from the prior June/July period. Let me say that again. For the year 2000, the data for the risk adjustment will be the hospital data that covers the period July 1, 1998, through June 30, 1999. So it is a period that is 6 months in advance of the beginning of the calendar year. The other option that we considered was to actually base it on the full calendar year prior to, which would have required us to have a retroactive adjustment to the rates once we got all the data in, calculated the risk scores and then made an adjustment.

We put out both of those options last September in our proposal to the public, and I think the vast majority of health plans suggested they wanted to have the 6 month approach that we have adopted, that is where the full risk adjustment comes into effect, but is not subsequently adjusted during the course of the year.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. COBURN [presiding]. Mr. Barrett.

Mr. BARRETT. Thank you very much, Mr. Chairman. You have touched, I think, in your written testimony and I apologize for not being here, on your concerns about gaming the system. Could you run through again what you are going to do to make sure that there is going to be little gaming of the system?

Mr. HASH. Well, we don't actually think there will be much of that because, first of all, we have eliminated from consideration discretionary hospital admissions, the 1-day stays. We think that to the degree people are worried about inappropriate hospitalizations to qualify an individual for a high-risk score the likelihood of that is not very large for a couple of reasons. One is the effect of the risk adjustment is not immediate after the hospitalization. It is in the year following the year in which the episode occurred.

And therefore there is some substantial uncertainty about whether that individual will even be in that plan a year from now. And second, to have admissions that were inappropriate, you would have to also encourage physicians and individual beneficiaries to undergo hospitalization which they traditionally are resistant to do. So we actually think we have built in enough adjustments to our system to mitigate against a possibility of any manipulation of the data Mr. BARRETT. Thank you. I want to touch a little bit on the, and you made reference to this in your comments about the disparity, the payment disparity. And I come from a State where there is a concern that the payments are lower than they should be. Can you talk about how in the first 2 years because of the Balanced Budget limitations, we were not able really to bring up the floor. You would concur with that?

Mr. HASH. Well, the things that were supposed to happen as a result of the BBA were three things. One, the floor was to be raised. There was a minimum update of 2 percent each year. And there were a series of blended rates that were being phased in over

the course of the 5 years of the BBA. What the statute says was, you must do the floor and the 2 percent update and if there is any money left over, you can actually fund the additional cost of a blended approach.

It turned out that in the first 2 years, 1998 and 1999, the floor came up, 2 percent was offered, but in no county that would otherwise have gotten a blended rate was that actually able to be——

Mr. BARRETT. For the 2 percent, did that go to everyone? So did you actually have a situation——

Mr. HASH. Well, that was the minimum now——

Mr. BARRETT. Okay.

Mr. HASH. For people who were affected by the floor, we had payments as low as about $220 a month. The floor was originally, I think, $370. So people who went from $220 to $370, had a very substantial, greater than 2 percent, gain. It is fair to say, however, that in many of those counties there are not any managed care plans.

So that from a plan perspective, the raising of the floor probably didn't affect a lot of plans because they weren't serving areas where the floor was raised

Mr. BARRETT. And I assume that you have studies that would show where the plans are most prolific.

Mr. HASH. Oh, yes.

Mr. BARRETT. In other words, I am assuming that, I would be interested in getting some of that information.

Mr. HASH. Be happy to supply that.

Mr. BARRETT. Because intuitively I would think that a lot of these areas that have the low reimbursement rates are going to, not going to have this. So this becomes sort of an academic exercise if we don't have people who are providing these plans.

Mr. HASH. Well, I think it is fair to say that most of the penetration of managed care in the Medicare Program is in geographical areas where the payments made by the Program are relatively high. We do have that data and would be happy to share it with you.

[The following was received for the record:]

Managed Care Penetration and Weighted Payment Rates for Counties, Sorted by Payment Decile, 1998

Payment Rate*		Average Payment**	Penetration Rate
High	Low		
$783	$506	$587	26.31%
$506	$461	$487	19.18%
$461	$435	$446	13.97%
$435	$413	$422	11.53%
$413	$394	$403	11.95%
$393	$376	$386	8.80%
$376	$367	$371	6.73%
$367	$367	$367	4.67%

Note: In the above table, counties were sorted by the aged M+C payment rate (highest to lowest) and then divided into 10 equal groups. For example, the 1st decile represents the 10% of counties with the highest payment rates. The average payment for these counties is $587 and the penetration rate is approximately 26%. There are many factor's that weigh on a plan's decision to enter or leave a market. Payment rate may be one factor.

*The bottom three deciles, representing plans receiving the floor payment, were combined into one group for analysis.

**Weighted by number of risk enrollees.

Source: HCFA, Office of Legislation, March 1999

Mr. BARRETT. And just to follow up on that. As I follow the Medicare Commission Reports that talk about prescription drug coverage and talk about maybe having more incentives for people who are in HMO's. Again, my concern is that we are leaving a lot of people behind if the emphasis is going to be in that area. And there are huge parts of this country where managed care just is simply not interested in going because of that.

So all of a sudden we are looking at a multi-tiered system based more on geography than anything else.

Mr. HASH. Well, I guess to respond to that I would say, that is one of the reasons, at least as the President has looked at and talked about the deliberations in the bi-partisan Commission, I think he has been very outspoken about the need to maintain a defined, benefit package across-the-board for all Medicare beneficiaries regardless of whether they are in a private plan or in the traditional fee-for-service program.

So in order to make sure that everywhere the beneficiaries have a guarantee of a defined benefit package, including prescription drugs. I mean that is a core, or should be a core feature of any strengthening or improvement of the Medicare Program——

Mr. BARRETT. Okay, thank you.

Mr. COBURN. Mr. Barrett, did you want to request that he send us that information?

Mr. BARRETT. Yes, please.

Mr. COBURN. If you would, Mr. Hash? Would you, Mr. Hash?

Mr. HASH. Be happy to.

Mr. COBURN. In terms of the comparison of rates and participation rates based on payments. The gentleman from Florida.

Mr. STEARNS. I thank you, Mr. Chairman. Mr. Hash, I have here a document that is dated December 11, 1998, and I understand the committee just recently got this. It is a list of risk plans not renewing or reducing services to areas for 1999. And going through this I notice Florida is almost two pages here. And a lot of these counties are in my Congressional District, Clay, Baker, Lake, Marion, but you even have Orange County here, which is Orlando.

You have Volusia County which is Daytona Beach. So you have counties here like Clay, in my district, which is basically a lot of working people. And yet all these HMO's are leaving. So I guess, for the record, tell me why they are leaving again?

Mr. HASH. Well, I think there are a variety of reasons, as I, you might not have been here but I talked about this a little bit earlier. And the variety of reasons includes plans' decisions about their relative market position, their penetration in the market, and the competitiveness of the market. Obviously, some of it has to do with their anticipation of what Medicare rates are going to be like.

There was further uncertainty about what the risk adjustment methodology, how that would affect them. There are a variety of factors and they are not easily generalizable because each market, I think, is very different. And I think the decisions that were made in Florida are ones that are unique to the market place.

Mr. STEARNS. That is my main question. Is there something about Florida that is different than other States?

Mr. HASH. No, no, when I said unique, I mean that the particular decision by a given plan to withdrawal completely or reduce

their service area is affected by the particular circumstances in which they find themselves. That could be that they have a relatively small penetration into the Medicare market place and do not feel, in terms of the numbers that they have been able to enroll, that it provides an adequate base in terms of taking the risk on for this population.

Mr. STEARNS. Mr. Hash, in three of these which are in my Congressional District, there were no HMO's. In other words, this HMO that left was the only one.

Mr. HASH. Right.

Mr. STEARNS. There was no competition.

Mr. HASH. Right.

Mr. STEARNS. And they, when I talked to them, they always complain they are not getting enough money from you to make it worthwhile and they want to see a reimbursement similar to what Miami is getting. Is that a legitimate argument?

Mr. HASH. Well, I——

Mr. STEARNS. They say because there is less population, and the cost of living is less. And Miami costs more, so Miami is getting more. And so they go to Miami and they don't go to——

Mr. HASH. The reasons the payments vary so dramatically in the Medicare+Choice program have to do with the range and variation in the Medicare costs. That is what really is at the base of what the rate is in any given area. It is what has been the historical cost experienced in terms of the price paid for services and the utilization patterns for services in that area.

In a place like Dade County, both price and utilization historically has been at the top of the list of Medicare utilization and price across the country. That translates into among the very highest payment rates. In other areas of the country and other counties even I am sure in the State of Florida, price and utilization rates in the Medicare Program over time have been very much different than what is going on in Dade County.

Mr. STEARNS. This is my last question, Mr. Chairman. I know we have to vote. Maybe in one or two sentences, if you had the power and you could make the decision today and you had the genie right on your shoulder, what would you do in two sentences to make universal availability of HMO's across this country in an affordable, accessible way.

Mr. HASH. I think that is a question I can't answer in one or two sentences.

Mr. STEARNS. You have got a genie on your shoulder now.

Mr. HASH. But I would like to work with you to try to find the answer to that.

Mr. STEARNS. You sound like a politician. Thank you, Mr. Chairman.

Mr. COBURN. I just want to confirm with you, Mr. Hash, that we will get the comparison from 1990 to now on renewals/non-renewals, if you would. And your staff is going to remain here for the rest? Okay, thank you very much.

Mr. HASH. Thank you, Mr. Chairman.

Mr. COBURN. And we will adjourn until I guess, until the chairman gets back. How is that?

[Brief recess.]

Mr. BILIRAKIS. The hearing will come to order. The second panel will consist of Dr. Gail Wilensky, Chair of the Medicare Payment Advisory Commission and Bill Scanlon. Mr. Scanlon is Director of Health Financing and Public Health of the United States General Accounting Office. Welcome, Dr. Wilensky and Mr. Scanlon. You have been here before, both of you have and how.

Your written testimony is obviously a part of the record. We will set the clock at 5 minutes. If you feel you have got to exceed that, I don't think we will shut you off. We will start off with Dr. Wilensky.

STATEMENTS OF GAIL R. WILENSKY, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION; AND WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE

Ms. WILENSKY. Thank you. Thank you very much, Chairman Bilirakis and members of the subcommittee for inviting me to be here. I am here in my role as Chair of the Medicare Payment Advisory Commission. I want to summarize a few thoughts that I would like to leave you with following the discussion that went on in the very interesting first panel.

The first point is just to remind you what the problem is that you are trying to fix with regard to risk adjustment. And that is that payments to plans have not reflected predictable differences—and the emphasis on the predictable—in seniors' health care spending. And so what we have seen from HCFA is an attempt to make an interim adjustment to the payment that relies on data from in-patient stays on the patients' diagnosis as a better way to adjust payments to reflect the seniors' health status.

We have already been using age and sex and their employment, whether or not they are institutionalized and whether they are on Medicaid. But as you well know, that has not been a very good way to pick up other predictable differences based on their health care status. Now the plans have taken a number of hits on their base payment as a result of the Balanced Budget Act. And you are probably going to hear more about that later.

But I think it is important to distinguish between whether or not the base payment to a plan is adequate or right—particularly as a result of the various changes that have occurred from the Balanced Budget Act—and whether the relative payments between plans and between the plans and traditional Medicare are right. What this is supposed to accomplish, the risk adjustment, is to make the relative payments right. You could agree on that and still have an argument about whether the base has been hit too hard or will be hit too hard in the future.

There has clearly been stronger reductions because of the stronger than anticipated reductions in fee-for-service spending from the Balanced Budget Act and there have been a number of administrative requirements that have increased spending needs for the plans, including some of the data reporting requirements that have been put on them. And this risk adjustment, it appears, will also reduce overall the payments to the plans. But it doesn't address the issue about the relative payments.

Third point is that the focus ought not to be thought of as punishing plans, but rather trying to provide incentives so that plans who are willing to, or who want to take on chronically ill patients, get paid appropriately so they can do that and have that payment reflected in their premiums. Now there are some appropriate concerns that have been raised if they only use in-patient data.

They are basing the expenditures on what we know from fee-for-service data, and as I have talked about, it is one more hit, it looks like overall. But the fact is I think HCFA has done the very best that it could, given the requirements of beginning to implement risk adjustment January 2000. As you know, they only have data from the in-patient stay. They are phasing in the change. They will phase it in over a several year period.

They are backloading the change, that is it is a little change in the beginning. Most of the change occurs in the last few years. And by the time they finish the phase in, full encounter data, that is data from the out-patient setting, should be available. And that will make it a much better risk adjustment. So in conclusion I would like to say that while I think there can be some question about some of the changes that have occurred this year, about when the appropriate date is to ask health care plans to put in the information on their premium and benefit combinations to maybe move it a little later than it is now in statute in May.

There can be some questions raised about whether the requirements for reporting of data are too onerous or too costly or whether the base payment is right. But the risk adjustment that has been proposed by HCFA, I think is a very reasonable rule. I think by having it phased in, by backloading the impact, by using full encounter data as soon as they can, they have really produced a very reasonable rule. And I would urge you to proceed with it. Thank you.

[The prepared statement of Gail R. Wilensky follows.]

PREPARED STATEMENT OF GAIL R. WILENSKY, CHAIR, MEDICARE PAYMENT ADVISORY COMMISSION

Good morning Chairman Bilirakis and members of the Subcommittee. I am Gail Wilensky, Chair of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss the issue of risk adjustment and the Medicare+Choice program.

SUMMARY

The system used to adjust payments to Medicare's risk-contracting plans and now Medicare+Choice plans has been widely acknowledged to be inadequate because it does not accurately reflect predictable differences in enrollees' health spending. As a result, Medicare has overpaid plans to care for relatively healthy enrollees and underpaid plans to care for those in poorer health. Overall, payments have exceeded plans' costs of providing the basic Medicare benefit package.

A better risk adjustment system would improve payment equity across plans and reduce Medicare's overpayments to plans. The interim risk adjustment system proposed by the Health Care Financing Administration (HCFA)—which relies on principal diagnoses from inpatient hospital stays—is imperfect, but it represents a step in the right direction by making payments correspond more closely to enrollees' health needs. Moreover, many of the limitations of the proposed interim system could be mitigated by moving to a system based on diagnosis data from all sites of care. MedPAC supports HCFA's efforts to do this effective for payments in 2004.

Adopting any new system of risk adjustment would introduce swings in payments to plans. Accordingly, MedPAC supports the phase-in proposed by HCFA that backloads the impact.

RISK ADJUSTMENT AND WHY IT IS NEEDED

Risk adjustment is a term used to describe incorporating predictable differences in health status and service needs into the capitation payments made to health plans. When payments are risk adjusted, plans receive larger payments for their relatively sick enrollees and smaller payments for their healthier ones.

In Medicare, risk adjustment is intended both to make payments equitable across Medicare+Choice plans and to account for differences in the mix of enrollees between the traditional fee-for-service program and the Medicare+Choice program. Put another way, risk adjustment may be viewed as a means of encouraging health plans to serve beneficiaries with severe or chronic illnesses by paying plans more to care for them.

Medicare beneficiaries' needs for health services—inpatient care, physician visits, and so on—vary, and this variation has both a random component and a systematic component. The random component reflects service needs that are, by definition, unpredictable, so that if there were no other differences among beneficiaries, risk adjustment would not be necessary. In such a situation, unexpectedly high costs for some enrollees in a plan would be offset by unexpectedly low costs for other enrollees. Given sufficient numbers of enrollees, payments to plans would be correct on average.

In fact, there are differences among beneficiaries that lead to systematic and predictable differences in their needs for health services. For example, older people use more services than younger people, and people with severe or chronic illnesses use more services than others. These predictable differences in the use of services—whether they are predictable either by health plans or by enrollees themselves—introduce the potential for risk selection. If no adjustments are made to account for these differences, plans will be overpaid for healthy enrollees and underpaid for sick enrollees. Accordingly, they will have an incentive to enroll beneficiaries whose expected costs are below average, because they will still receive the average payment. If plans act on this incentive and successfully attract relatively healthy beneficiaries, aggregate payments will be too high.

MEDICARE'S CURRENT SYSTEM OF RISK ADJUSTMENT

Currently, Medicare adjusts payments to private health plans to reflect only differences among enrollees in their demographic characteristics (age and sex), employment status, institutional status, and eligibility for Medicaid. This risk adjustment system accounts for the relatively greater use of health services of older beneficiaries and those who are institutionalized, and the relatively lower expected costs associated with working enrollees who have primary coverage through their employers. However, it does not account for variation due to differences in health status. Until 1998, the original payment method paid 95 percent of expected fee-for-service spending for beneficiaries with similar characteristics, which was intended to account for health plans' ability to deliver care more efficiently. Now, payments are based on updated 1997 rates.

Payment inequity and overpayment under the current system

A common complaint about the current system is that plans have experienced significant favorable risk selection—enrollment of relatively healthy beneficiaries—that is not reflected in their payments. Because it does not take health status into account, the current system rewards organizations that attract healthier enrollees because it does a very poor job of accounting for predictable differences in health spending. Plans are thus paid the same amount for two beneficiaries with identical demographic characteristics, even though differences in their health status would suggest that one will be much more costly than the other.

Empirical research supports the assertion that plans have experienced favorable selection while their payments have been based on average risks within demographic groups. For example, Riley and colleagues (1996) found that in 1994 the predicted costs of Medicare risk plan enrollees were 12 percent lower, on average, than the predicted costs of fee-for-service enrollees with the same demographic characteristics. Because payments currently are adjusted only for demographic differences, even setting rates at 95 percent of the amount Medicare expected to spend for a beneficiary in the fee-for-service program resulted in overpayments of as much as 7 percent (Riley et al. 1996, Hill et al. 1992). Those overpayments are in part why Medicare risk plans have been able to offer expanded coverage to enrollees.

Some favorable risk selection may be inevitable because the methods organizations use to recruit enrollees might not reach people with poor health status, such as the institutionalized, or because healthy people may be less particular about being able to see a specific physician. Moreover, even if selection to plans has been

favorable in the aggregate, that does not mean that all individual plans have experienced favorable selection. For example, one study shows that mortality and hospitalization rates rise as length of managed care enrollment increases (PPRC 1996). This "regression towards the mean" means that in terms of their use of health services, managed care enrollees become more like fee-for-service beneficiaries over time. Thus, plans that have participated in Medicare longest and have long-tenured enrollees may see less favorable selection.

Risk adjustment requirements in the Balanced Budget Act

In response to concerns about the current system, the Balanced Budget Act of 1997 (BBA) directed HCFA to develop a new risk adjustment system. The rationale of the Congress for mandating the new system was to make Medicare's payments to Medicare+Choice organizations more accurately reflect predictable differences in health spending by enrollees. This new system should improve Medicare+Choice by making payments more equitable across plans and making them reflect the generally better health of Medicare+Choice enrollees as compared with fee-for-service beneficiaries.

The BBA required the new risk adjustment system to use enrollees' health status and demographic characteristics to account for variations in their expected spending. It laid out a very tight time schedule, requiring HCFA to implement the system by January 1, 2000.To meet that schedule, the agency must:

- publish a preliminary notice by January 15, 1999, describing the changes in methods and assumptions it will use to determine payment rates for 2000, compared with those for 1999 (HCFA 1999);
- publish a final notice by March 1, 1999, on the payment rates for 2000 and the risk and other factors it will use to adjust those payment rates; and
- submit a report to the Congress that describes the risk adjustment method it will implement with the new payment rates, also by March 1, 1999.

While HCFA has supported research to develop improved risk adjustment methods for more than a decade, implementing the new system has required HCFA to collect and analyze a substantial amount of new data in a short period of time. The agency must measure not only the health status of beneficiaries enrolled in Medicare+Choice plans, but health status and subsequent spending for beneficiaries in the traditional fee-for-service program.

HCFA must collect data from Medicare+Choice organizations both to determine monthly payments for each enrollee starting in 2000 and to inform Medicare+Choice organizations about the anticipated effects of the new risk adjustment system.

HCFA must measure health status and spending for fee-for-service beneficiaries for two reasons. First, the agency must estimate risk scores that measure relative levels of expected spending for beneficiaries with different combinations of health conditions and demographic characteristics. These scores require beneficiary-specific data on health conditions, demographic characteristics, and annual Medicare spending for covered services that are currently available only for beneficiaries in the traditional fee-for-service program. Second, once the new risk scores are developed, HCFA must adjust the per capita monthly payment rate for each county—the county rate book—to reflect the county's expected level of per capita spending for a beneficiary with national average health and demographic characteristics.

To facilitate these tasks, the BBA permitted HCFA to collect encounter data—which provide information similar to claims data—on hospital inpatient stays from Medicare+Choice organizations, but not before January 1, 1998. Starting July 1, 1998, HCFA could collect encounter data from other providers of care such as physician offices, hospital outpatient departments, skilled nursing facilities, and home health agencies. HCFA will be able to use the diagnoses reported in the encounter data to develop indicators of beneficiary health status.

HCFA has indicated it has been meeting the time requirements of the BBA and has collected almost complete hospital inpatient encounter data records from nearly all organizations. A small number of organizations have supplied incomplete data, and HCFA is working with them to get complete data. Some organizations are less confident and believe the data generally are not complete due to systems problems. However, the actual risk scores will be based on the next round of data collection, which should afford an opportunity to work out existing problems.

HCFA'S PROPOSED INTERIM SYSTEM

The schedule outlined in the BBA restricted HCFA to adopt, at least initially, an interim system in which health status will be measured using only hospital inpatient diagnoses. Before the Congress passed the BBA, HCFA argued that it needed data as soon as possible to implement an improved risk adjustment system. How-

ever, HCFA and the Congress recognized that Medicare+Choice organizations could not establish systems for reporting data from sites of care other than hospital inpatient departments in time for implementation by January 1, 2000. Therefore, HCFA indicated to the Congress it needed inpatient data by a particular date and left the Congress to determine the remaining time frame.

Description of the proposed interim system

In the interim system, HCFA will determine payments to Medicare+Choice organizations according to the following process. First, HCFA will characterize beneficiaries by:

- age and sex;
- principal diagnoses associated with any inpatient hospital stays they had during the previous year;[1]
- eligibility for Medicaid benefits during the previous year; and
- for aged beneficiaries, previous eligibility for Medicare on the basis of a disability.

Based on this classification, HCFA will determine prospective risk scores for Medicare+Choice enrollees (see the Appendix for more detail). Risk scores are intended to measure enrollees' expected spending in the forthcoming payment year relative to that of the average beneficiary in the traditional fee-for-service program. As in the current risk adjustment system, spending patterns in the traditional fee-for-service program will be treated as a baseline, so the risk score associated with each combination of demographic and health status factors will be estimated using fee-for-service data.[2]

In the last step, HCFA will calculate payments for enrollees as the product of three factors:

- the year 2000 payment amount for enrollees' county of residence from the county rate book;
- a factor that will adjust the county payment rate to reflect the change in risk measurement methods; and
- the enrollees' risk scores based on the interim system.

The county adjustment factors are needed to change the county payment amounts so they are consistent with the new system. Under the current system, each county payment rate is based on the updated 1997 payment rate, which reflects the current expected fee-for-service spending per capita in the county for a beneficiary with the national average demographic profile. Because the new risk adjustment system captures risk differences among beneficiaries more precisely than does the current system, HCFA needs to recalibrate the county amounts using the new adjusters. This method will ensure that the county payment rates reflect the 1997 expected fee-for-service spending per capita in the county for a national average beneficiary, as measured by the new system.

The interim system intended to improve payment equity

The interim risk adjustment system should be an improvement over the current system because payments to organizations will more accurately reflect the predictable differences in health spending by their enrollees. If it works as intended, the system will encourage organizations to compete on the basis of how effectively they manage care and not reward plans for attracting favorable risks.

The interim system is consistent with the BBA's objectives for risk adjustment. First, it will encourage organizations to compete on factors other than risk selection because the profits from favorable selection will be lower. Second, organizations may have more resources for developing specialized care management programs for enrollees with serious conditions, which may lead to improvements in efficiency and in the quality of care enrollees receive. Finally, aggregate overpayments to Medicare+Choice organizations that result from enrolling healthier Medicare beneficiaries may be reduced.

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[1] Inpatient diagnoses are based on encounter data submitted by organizations for current enrollees and on Medicare fee-for-service claims for new enrollees who were previously in the traditional program. Risk scores for beneficiaries who are newly eligible for Medicare and who enroll in a Medicare+Choice plan will be based solely on their demographic characteristics. This is necessary because HCFA lacks a claims history for these beneficiaries.

[2] In principle, risk scores could (perhaps should) be estimated using Medicare+Choice spending patterns, but data on annual spending for covered services, which are needed to estimate expected spending given enrollees' diagnoses and demographic characteristics, are not now available for Medicare+Choice enrollees.

Potential concerns with the interim system

Despite these improvements over the current system, the interim system's dependence on hospital inpatient diagnoses raises several potential concerns that policymakers should monitor closely.

Incentives to hospitalize inappropriately. Because organizations will receive higher payments only for enrollees who have been hospitalized, the proposed system may create incentives for Medicare+Choice organizations to hospitalize enrollees inappropriately. However, the impact of such incentives is likely to be mitigated by a number of factors.

- First, payments for enrollees' hospital stays are based on their expected spending in the year following the stay, so the incremental payment may be lower in many cases than the hospitalization cost the organization incurred.
- Second, organizations will not receive an increased payment until the calendar year after a hospitalization, and then only if the hospitalized beneficiary remains enrolled in the same organization.[3]
- Finally, organizations would have to influence physicians to hospitalize more patients and to overcome resistance on the part of enrollees to being hospitalized.

To further counteract any incentive to hospitalize, HCFA will treat enrollees with one-day inpatient stays and those with diagnoses for which hospitalization is discretionary the same as enrollees who were not hospitalized. HCFA considers a hospitalization to be discretionary if the principal diagnosis represents only a minor or transitory disease or disorder, is rarely the main cause of an inpatient stay, or is vague or ambiguous.

Adjustments based on fee-for-service patterns. A second potential problem is that risk scores based on fee-for-service hospitalization patterns may understate the riskiness of certain Medicare+Choice enrollees. This understatement will occur if Medicare+Choice organizations substitute other sites of care in place of hospitalizations more frequently than do providers in traditional fee-for-service Medicare. If this were true, Medicare+Choice enrollees with serious conditions would be hospitalized less often and would receive lower risk scores, on average, than fee-for-service beneficiaries with comparable conditions and demographic characteristics.

How serious this problem could be is unclear. Hill and colleagues (1992) found that Medicare managed care organizations did not reduce the hospitalization rate relative to fee-for-service Medicare. But Medicare+Choice organizations have also argued that they hospitalize comparable patients for shorter stays than do fee-for-service providers in traditional Medicare, and results from Hill and others support this argument. To the extent organizations shorten hospital stays to one day, HCFA's proposal to treat enrollees with one-day stays the same as enrollees without inpatient stays will compound any understatement caused by calibrating risk scores based on fee-for-service data.

Potential for large changes in payments. A third issue is that implementing any improvements in risk adjustment will often lead to changes in payments to some individual plans that are much larger than the change in aggregate Medicare+Choice payments. Under the interim system, these changes could affect some Medicare+Choice organizations' decisions to participate in some or all of the market areas they serve for Medicare and disrupt Medicare+Choice coverage for some beneficiaries.

Medicare+Choice organizations are understandably concerned about the effects of HCFA's new risk adjustment system on their future payments. Other things being equal, adoption of this new system on January 1, 2000, will change payments for individual organizations and reduce overall Medicare+Choice payments. However, the full effects of the new system are somewhat uncertain because the data that HCFA will use to determine payments to organizations in 2000 will not be available until late in 1999 when enrollment data are available.

MedPAC has not yet made a comprehensive assessment of the impact of the new system on specific plans. But the amounts involved will be significant. Based on preliminary data, HCFA estimates that if the new system were implemented immediately and if there were no changes in the composition of enrollment:

- variation in payments for individuals would range by a factor of about 25, compared with the current variation of about 6;
- additional payments would be made for about 12 percent of enrollees, and about 20 percent of total payments would be redistributed;
- aggregate plan payments would fall by 7.6 percent; and

[3] In fact, there will be a lag of six months between collecting diagnosis data and calculating risk scores. Thus, payments for calendar 2000 will be based on data collected between July 1, 1998 and June 30, 1999.

- payments to some plans could fall by 15 percent, whereas payments to others could increase by 5 percent.

Inpatient data inadequate. Finally, some analysts have expressed concerns that payments to Medicare+Choice organizations under the interim system will not fully account for measurable and predictable differences in spending among their enrollees because there is diagnosis and health status information that is not reflected in the demographic and hospital diagnosis data used. As a result, organizations that attract seriously ill enrollees still will be underpaid, while those that attract healthy ones will continue to be overpaid. This concern is valid, but the new system nonetheless represents a substantial improvement over the existing system.

MEDPAC'S RECOMMENDATIONS

In MedPAC's *Report to the Congress: Medicare Payment Policy* that will be released next week, the Commission makes two recommendations that could mitigate many of the concerns associated with a new risk adjustment system for Medicare+Choice.[4]

Recommendation to use diagnosis data from all sites of care

Many of the problems cited for the proposed interim system could be mitigated by replacing it with a permanent one in which health status is based on diagnoses assigned during both inpatient hospital and other types of health care encounters. Thus, MedPAC recommends that:

> As quickly as feasible, the Secretary should develop the capability to use diagnosis data from all sites of care for risk adjustment.

In its January 15, 1999, 45-day risk adjustment notice, HCFA indicated it intends to replace the interim system on January 1, 2004, with a comprehensive system based on diagnoses from beneficiaries' encounters with all major types of providers. To make that possible, HCFA will require organizations to augment their hospital inpatient data with information from enrollees' encounters in physicians' offices, hospital outpatient departments, skilled nursing facilities, and home health agencies. However, this requirement will not be implemented before October 1, 1999.

Recommendation to phase in the interim system to cushion its effects on payments

MedPAC agrees with the Secretary's plan to phase in the interim risk adjustment system:

> The Secretary's plan to phase in the interim risk adjustment system—with a method that uses a weighted blend of the payment amounts that would apply under the interim system and those that would apply under the current system—is sound. The weight on the interim payment amounts should be back-end loaded. That is, the weights should be relatively low in the first years so that most organizations will not experience extreme changes in their total payments.

The phase-in should reduce the number of organizations that withdraw from the Medicare+Choice program, but it also will slow the benefits of adopting the interim risk adjustment system. In addition, the phase-in will raise Medicare spending because the reduction in payments that otherwise might occur under the interim system will not be fully realized.

Blended payments will be made during 2000 through 2003. In 2000, payments will be calculated using 90 percent of the existing system and 10 percent on the interim system.[5] Progressively lower weights will be assigned to the existing system in 2001 through 2003. In 2004, payments will be based on full implementation of a comprehensive risk adjustment system that uses data from all sites of care.

CONCLUSION

Changes in Medicare's rules for private health plans participating in the program have had both intended and unintended consequences. These changes, introduced in conjunction with the new Medicare+Choice program, were designed to improve Medicare's risk contracting program by increasing the fairness of the distribution

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[4] Risk adjustment may reduce incentives for risk selection, but will not by itself create neutral financial incentives to provide specific services. In its March 1998 Report to the Congress, MedPAC recommended a large-scale demonstration of partial capitation or other methods that would pay plans partly on the basis of a capitated rate and partly on the basis of payment for services used. The Commission continues to support such a demonstration to test the merits of supplementing risk adjustment with risk sharing.

[5] As an example of how the blend will work in 2000, consider an organization that would receive a monthly payment for an enrollee of $470 under the interim system and $500 under the current system. In 2000, the blended monthly payment would be: (.10)x($470) + (.90)x($500) = $497.

of payments to health plans, by creating incentives to improve quality of care, and by helping beneficiaries to make more informed choices. But taken together with lower base payment updates attributable to the BBA and to unexpected slowing in the growth of fee-for-service Medicare spending, the new rules may have made participation in Medicare less attractive from the plans' perspective. Plans have expressed particular concerns about the combined impact of lower base payment updates under the BBA and possible decreases from that base as risk adjustment is implemented.

Improving Medicare's current risk adjustment system is essential. Risk adjustment is about getting relative payment rates right, so that payments for enrollees in the Medicare+Choice program more closely match their expected costs. It is appropriate that the new system of risk adjustment be phased in, both to avoid any instability that sudden swings in payments to health plans could have for their enrollees and to allow time for policymakers to assess how it is working, but the benefits of better risk adjustment should not be delayed more than necessary. While the Commission recognizes that the transition to the new Medicare+Choice program has been less smooth than many had hoped, we believe the issues raised during the transition should be considered separately from the issue of improving Medicare's system of risk adjustment.

Mr. BILIRAKIS. Thank you, Doctor. Mr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON

Mr. SCANLON. Thank you very much, Mr. Chairman and members of the subcommittee. I am pleased to be here today as you consider HCFA's proposed risk adjuster for rates paid to Medicare+Choice Plans. As you have heard from several sources, Medicare's current risk adjuster falls far short of its intended goal of assuring appropriate payment for such plans. In 1997, we issued a report on Medicare's payments to HMO's in California.

I think that the California study produced two findings which are very relevant for today's discussions. First of all, as other research has demonstrated for earlier time periods and using smaller numbers of beneficiaries, we found that the combination of the Medicare's pre-Balanced Budget Act rate setting method and the existence of favorable selection for HMO's, led to excessive capitation rates.

These rates, based on the experience of a sicker population of non-enrollees, were paying for the services needed by the healthier population of enrollees. We estimated that $1 billion in overpayments, representing about 16 percent of the total payments, were made to plans in 12 California counties. A quarter of these overpayments were attributable to computing each county's average rate using only the service experience of fee-for-service beneficiaries and not that of all beneficiaries.

Three-quarters of the overpayments was due to the failure of Medicare's risk adjuster to adequately lower those average rates to be consistent with managed care enrollees, better health and lower use of services. The second finding was that under Medicare's pre-Balanced Budget Act rate setting method, excess payments were continuing to grow with increased enrollment, rather than diminish, which many had speculated they would.

The reason was that as a county's managed care population grew, the concentrations of higher cost beneficiaries remaining in fee-for-service also grew. Rates based on the sicker fee-for-service populations resulted in increasingly excessive payments relative to the average better health of the managed care population. Our work specifically showed that HMO's in counties with the highest

managed care penetration received a higher share of excess payments.

The Balanced Budget Act modified the method for setting county rates, halting the spiral of increasing overpayments being built into these average rates. However, in establishing 1997 levels as the base, it is also clear that historical overpayments remain in today's capitation rates. The rates continue to be quite generous relative to the expected use of medical services by Medicare's managed care population.

However, excess payments in the aggregate do not mean that every plan is overpaid. A fundamental problem with Medicare's current risk adjustment method is that it puts plans enrolling high cost beneficiaries at a competitive disadvantage. Demographic information alone is inadequate to predict an enrollee's health care cost. As a result, a current risk adjustment does not adequately raise a plan's capitation rate enough to pay appropriately for sicker beneficiaries' use of services.

As a practical matter, Medicare managed care plans receiving a fixed payment per enrollee are not likely to go out of their way to encourage Medicare's frailest seniors to join their plans. We and others have repeatedly called for a health-based adjuster, HCFA's proposed method using hospital and patient data, while not perfect, is headed in the right direction.

HCFA has taken steps to ensure that the shortcomings associated with having to use these data are reduced. It was an appropriate step to seek expert clinical input to identify and exclude from the risk adjustment calculations hospitalizations that were more likely discretionary or not predictive of future costs. We also find that HCFA's phase in approach is prudent.

It avoids rapid payment changes that plans may find difficult and that could adversely affect beneficiaries if plans respond by suddenly altering their benefit packages or reconsidering their commitment to the Medicare+Choice Program. Nevertheless, because having encountered data on Medicare managed care enrollees' use of services in all settings is critical to improving risk adjustment, we urge that plans participating in Medicare+Choice collect and report these data to HCFA as soon as possible.

All plans may not be able to submit such data quickly, so it may not be feasible to accelerate the transition to the comprehensive risk adjusters currently planned for the year 2004. However, having full encounter data from some plans, may allow HCFA to assess the appropriateness of the interim risk adjusters and make modifications during the transition period, if appropriate.

Overall, we believe that the new health-based risk adjuster system will help reduce overpayments to managed care plans and will also make payments fairer to plans enrolling Medicare's costliest beneficiaries. Thank you, Mr. Chairman. I would be happy to answer any questions you or the members may have.

[The prepared statement of William J.. Scanlon follows.]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH EDUCATION AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today as you address the question of adjusting Medicare's payments to managed care plans in the Medicare+Choice program. Although the subject matter is tech-

nical, its implications are significant for Medicare's greater use of managed care. The Balanced Budget Act of 1997 (BBA) includes provisions designed to slow the growth of Medicare payments overall. BBA also encourages the expansion of managed care in its creation of Medicare+Choice, designed to offer beneficiaries more health plan options beyond those available through Medicare's health maintenance organizations (HMO). BBA provisions modify the method used to pay health plans, and it is the details for implementing these provisions—representing billions of dollars in savings—that are under discussion here today.

Managed care plans receive from Medicare a fixed monthly payment, called a capitation payment, for each beneficiary they enroll. Because the payment is fixed per enrollee, regardless of what the plan spends for each enrollee's care, health plans lack the incentive to provide unnecessary services. However, the enrollment of beneficiaries in managed care plans has not saved the government money as expected, mainly for two reasons. First, as we and others previously determined, Medicare's capitation rates are excessive because payments are based on health care spending for the average non-enrolled beneficiary, while the plans' enrollees tend to be healthier than average.[1] Second, instead of diminishing as more beneficiaries enrolled in managed care, excess payments per enrollee continued to grow. To correct these problems, BBA changed the rate-setting formula used by the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare. It required that most of the rate-setting provisions be in place in 1998 and required that HCFA replace Medicare's current risk adjuster—the mechanism that modifies a plan's average capitation rate to better reflect an enrollee's expected medical costs—with a new one to be implemented in 2000. The risk adjuster in place has been widely criticized as a major factor in the HMO overpayment problem.

In considering Medicare's new rate-setting method, my comments today will focus on (1) the importance of improving the current risk adjustment method, (2) the implications of rate-setting changes implemented in 1998, and (3) the advantages and drawbacks of HCFA's proposed new interim risk adjuster. My comments are based on information drawn from our issued work on this subject, supplemented by relevant published studies and interviews with HCFA officials.

In summary, Medicare's current risk adjuster has failed to protect taxpayers, certain plans, and beneficiaries, underscoring the urgency of replacing it with a health-based risk adjuster.

- Studies by us and others show that methodological flaws have led to billions of dollars in excess payments and inappropriate payment disparities.
- BBA provisions now in place may reduce, but not eliminate, excess payments; and payment disparities persist that could jeopardize plan participation and access to managed care for costlier seniors.
- The new risk adjuster required to be in place by 2000 is intended to improve estimates of health plan enrollees' medical costs. Better cost estimates producing fairer rates could reduce the unnecessary spending of taxpayer dollars while minimizing the financial disincentive for plans to serve a costly mix of beneficiaries.

The use of the new risk adjuster, while not perfect, is an interim step and improves on the one now in place. In addition, HCFA plans to phase in the use of the new adjuster, thereby recognizing the need to avoid sharp payment changes that could affect plans' offerings and diminish the attractiveness of the Medicare+Choice program to beneficiaries.

BACKGROUND

The long-term financial condition of Medicare is now one of the nation's most pressing problems. As the nation's largest health insurance program, Medicare's size and impact on all Americans is significant. The program covers about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion in fiscal year 1998. About 83 percent of the program's beneficiaries receive health care on a fee-for-service (FFS) basis, in which providers are reimbursed for each covered service they deliver to beneficiaries. The rest, about 6.8 million people, are provided care through more than 450 managed care plans, as of December 1, 1998.[2]

To extend the solvency of Medicare's Hospital Insurance Trust fund beyond 2008, BBA provided for substantial reforms in both the FFS and managed care compo-

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[1] *Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments* (GAO/HEHS-97-16, Apr. 25, 1997).

[2] About 90 percent of the 6.8 million Medicare beneficiaries are enrolled in managed care plans that receive fixed monthly capitation payments. The remainder are enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

nents of Medicare. BBA provisions are expected to achieve estimated Medicare savings that reduce the program's average annual growth rate by more than 3 percent, representing over $100 billion over 5 years.

One way in which BBA seeks to restructure Medicare is to encourage greater participation in Medicare+Choice. Under this program, BBA permits the creation of new types of Medicare health plans, such as preferred provider organizations and provider-sponsored organizations. BBA's emphasis on Medicare+Choice reflects the perspective that increased managed care enrollment will help slow Medicare spending while expanding beneficiaries' options in choosing health plans.

BBA also sought to improve the method for setting managed care plans' payment rates. In general terms, the pre-BBA rate-setting methodology worked as follows. Every year, HCFA estimated how much it would spend in each U.S. county to serve the "average" FFS beneficiary. It would then discount that amount by 5 percent under the assumption that the managed care plans provided care more efficiently than the unmanaged FFS system. The resulting amount constituted a base county rate to be paid to the plans operating in that county. Because some beneficiaries were expected to require more health services than others, HCFA "risk adjusted" the base rate up or down for each beneficiary, depending on certain beneficiary characteristics—specifically, age; sex; eligibility for Medicaid; employment status; and residence in an institution, such as a skilled nursing facility.[3]

BBA's new payment rate method seeks to address the two main factors contributing to excess payments: (1) the disparity in expected health costs between Medicare's FFS and managed care populations built into each county's base capitation rates and (2) the failure of the risk adjuster to correct for that disparity on an individual enrollee level. BBA required that a county's capitation rate equal the highest of

- a blended capitation rate, which reflects a combination of local and national average FFS spending from 1997, updated for increases in national spending;
- the previous year's county rate increased by 2 percent; or
- a minimum payment amount, called a floor, set equal to $367 in 1998 and updated each year.

Loosening the link between the current cost of Medicare's FFS population and counties' base rates helps prevent the excess payments from continuing to increase as more beneficiaries join managed care plans. BBA also acknowledges the need for individual enrollee adjustments by requiring the development of a risk adjustment method based on health status. The law requires that HCFA develop and report on the new risk adjuster by March 1 of this year and the method be in place by January 2000.[4]

MEDICARE'S CURRENT RISK ADJUSTMENT METHOD FAILS TO PREVENT OVERPAYMENTS AND APPROPRIATELY TARGET PAYMENTS TO PLANS

Risk adjustment is a tool to set capitation rates so that they reflect enrollees' expected health costs as accurately as possible. This tool is particularly important given Medicare's growing use of managed care and the phenomenon of favorable selection—the tendency of managed care plans to attract a population of Medicare seniors whose health costs are generally lower than those of the average program beneficiary. Our 1997 study on payments to California HMOs, which enrolled more than a third of Medicare's managed care population, found that Medicare overpaid plans by about 16 percent because HMO enrollees had costs that were lower than the average beneficiary's.[5]

Medicare's current risk adjuster cannot sufficiently lower rates to be consistent with the expected costs of managed care's healthier population. The reason is that Medicare's risk adjuster relies on demographic factors such as age and sex, which alone are poor predictors of an individual's health care costs. For example, two beneficiaries can be demographically identical (same age and sex), but one may experience occasional minor ailments while the other may suffer from a serious chronic condition. Without the use of health status factors to make that distinction, Medi-

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[3] Separate rates, using the same demographic traits, are calculated for beneficiaries who qualify for Medicare because of a disability (under age 65). Separate rates are also set for beneficiaries with end-stage renal disease (kidney failure).

[4] Technically, the law requires the Secretary of the Health and Human Services to develop, report, and implement the health-based risk adjustment method.

[5] GAO-HEHS-97-16, Apr. 25, 1997. This is consistent with a 1996 study by HCFA researchers finding that health plan enrollees had costs estimated at 12 to 14 percent below the average beneficiary's. (Riley and others, *HCFA Review,* 1996.)

care's risk adjuster produces excessive payments in compensating plans for their relatively lower cost enrollees.

The financial consequences of a poor risk adjuster are huge. In our 1997 study of California's payment rates, we estimated that Medicare paid about $1 billion in excess to health plans operating in the California in 1995. Shortly before we issued our report, the Physician Payment Review Commission (PPRC), now a part of the Medicare Payment Advisory Commission, estimated that annual excess payments to Medicare HMOs nationwide could total $2 billion.

Some analysts have speculated that, with growing enrollment, health plans would necessarily enroll a substantially larger share of less healthy beneficiaries, which would raise plans' costs and reduce Medicare's excess payments. Our 1997 analysis, however, showed that—rather than shrinking excess payments—the rapid growth in Medicare managed care enrollment actually exacerbated the situation. The counties with higher managed care enrollment had higher, not lower, excess payments. Data indicated that the sickest beneficiaries tended to remain in FFS while the healthier beneficiaries joined managed care plans. Excess payments grew with managed care enrollment partly because HCFA based the payment rates on average FFS spending, which increased as the pool of FFS beneficiaries shrank and, as a group, became less healthy.

Better risk adjustment is also important for plans that may not be adequately compensated for serving higher cost beneficiaries who enroll. Having enrollees who are sicker than the average mix of Medicare beneficiaries can alter a plan's costs significantly. About 10 percent of Medicare beneficiaries account for 60 percent of Medicare's annual expenditures. Without adequate risk adjustment, plans with more than their share of the costly beneficiaries are at a competitive disadvantage.

BBA PROVISIONS MAY REDUCE OVERPAYMENTS, BUT SUBSTANTIAL EXCESS LIKELY REMAINS

BBA contains several provisions, implemented in 1998, that are designed to improve Medicare's rate-setting method. Certain provisions seek to reduce excess payments and inappropriate geographic disparities. These changes represent steps in the right direction but do not eliminate the need for a health-based risk adjuster. Substantial excess payments likely persist, in part, because other BBA provisions tended to incorporate the excess that existed in 1997 into the current rates.

Certain BBA Provisions May Reduce Excess Payments but Are Not Substitutes for Improved Risk Adjustment

BBA aims to reduce the excess in Medicare's managed care payments in two ways. First, BBA holds down managed care per capita spending increases for 5 years. Specifically, BBA sets the factor used to update managed care payment rates equal to national per capita Medicare growth minus a specified percent: 0.8 percent in 1998 and 0.5 percent in each of the following 4 years.

BBA also provides for a methodological approach known as "blending," which may help reduce excess payments. The blended rate set for each county combines that county's 1997 rate, updated for increases in national Medicare spending, and a national average. The blending formula is currently weighted heavily toward local rates but will gradually change so that local and national rates will be weighted equally in 2003. Over time, blending will reduce the substantial variation in county payment rates that now exist. For, example, county rates ranged from a low of $380 to a high of $798 in 1999. Because of BBA-mandated budget neutrality and minimum payment constraints, no county received a blended rate in 1998 or 1999. Blending is expected to occur for the first time in 2000.

Blending may help reduce excess payments because high-rate counties (where excess payments are estimated to be concentrated) will receive smaller annual increases relative to low-rate counties. Evidence on the relationship between county payment rates and excess payments is provided in a 1997 PPRC study. PPRC reported that county payment rates tend to overestimate beneficiaries' health care costs in high-payment-rate areas and underestimate their costs in low-payment-rate areas.[6] PPRC found that a comprehensive health-based risk adjustment methodology would have lowered, for example, the average Miami-area payment rate from $616 to $460 in 1995. The same methodology would have raised the average payment rate in rural Minnesota from $263 to $310.

Blending is a rather blunt tool for addressing the excess payment problem, however, and does not obviate the need for improved risk adjustment. As the PPRC results indicate, not all high-rate counties have rates that are too high and not all

[6] Physician Payment Review Commission, *1997 Annual Report to the Congress.*

low-rate counties have rates that are too low. For example, PPRC's risk-adjustment methodology would have reduced the average payments in rural Michigan (a relatively low-payment-rate area) from $346 to $334. Furthermore, not all plans in high-rate counties may receive excess payments. Because payment rates are based on the expected costs of beneficiaries in average health, plans that attract costly beneficiaries may be underpaid by the current risk adjustment method.

Some BBA Provisions Have Tended to Incorporate Excess Payments From 1997 Into Current Rate Structure

BBA specified that 1997 county rates be used as the basis for all future county rates beginning in 1998. Although the law changed many aspects of the rate-setting formula, this BBA provision had the effect of incorporating the excess payments that existed in 1997 into all future rates.

As we testified before this Subcommittee in February 1997, HCFA's then current rate-setting methodology resulted in county rates that were generally too high. Simply put, instead of setting rates based on the expected cost of the average beneficiary in each county, the agency set rates based on the expected costs of serving FFS beneficiaries. If the agency had included the expected costs of serving managed care beneficiaries—who as a group tend to be healthier than FFS beneficiaries—the overall county average would have been lower. About one-quarter of the $1 billion in overpayments we estimated in our California study resulted from flaws in developing the county rate.

Excess payments are also built into current rates because BBA did not allow HCFA to adjust 1997 county rates for previous forecast errors—a critical component of the rate-setting process. Although the process for setting rates was extremely complex and involved separate adjustments for each county, annual payment rate updating was straightforward. Each fall, HCFA would forecast total Medicare spending for the following year; the estimated percentage spending increase, from the current year to the following year, was used to update the county rates. Before applying the increase, however, HCFA corrected any forecast errors from previous years. If HCFA discovered that previous forecasts had overestimated or underestimated the current spending, the update was appropriately adjusted.

HCFA actuaries now estimate, based on FFS claims data, that the 1997 managed care rates were too high by 4.2 percent. BBA, in establishing a new methodology for setting rates in 1998 and future years, specified that HCFA use the 1997 rates as the basis for the new rates. While the law permits HCFA to correct forecasts in future years, it did not include a provision that would have allowed HCFA to correct its forecast for 1997. Consequently, about $1.3 billion in overpayments were built into plans' annual payment rates beginning in 1998.

HCFA'S PROPOSED RISK ADJUSTMENT APPROACH IMPROVES ON CURRENT METHOD AND MINIMIZES DISRUPTION FOR PLANS AND BENEFICIARIES

HCFA's proposed interim health-based risk adjustment method—to be implemented in 2000—represents a major improvement over the current method. For the first time, Medicare managed care plans can expect to be paid more for serving beneficiaries with serious health problems and less for serving relatively healthy ones. The interim method relies exclusively on hospital inpatient data to measure health status. Although it would be better to measure health status with complete and reliable data from other settings, such as physicians' offices, these data are not yet available. In addition, HCFA's decision to phase in the new method will likely minimize disruptive plan pull-outs and altered benefit packages, which could occur if payment rate changes were implemented too suddenly.

Proposed Risk Adjustment Method Based on Available Hospital Inpatient Data

The proposed method, known as the Principal Inpatient Diagnostic Cost Group (PIP-DCG) method, would use hospital inpatient data to more accurately match managed care payments to beneficiaries' expected total Medicare costs. PIP-DCG would assign each individual to 1 of 15 categories if during the prior year they had been hospitalized for certain diagnoses. For example, a beneficiary who had been hospitalized for congestive heart failure would be placed in one category, while a beneficiary who had been hospitalized for a kidney infection would be placed in another. Those beneficiaries who were not hospitalized and those who were hospitalized for diagnoses not included in PIP-DCG—about 88 percent of all beneficiaries—would be placed in the base category. The next year's payment rate for each enrollee would be determined by the category the individual was placed in and by certain demographic data, such as age and sex. Rates for enrollees placed in one of the 15 prior hospitalization groups would be higher than rates for those in the base category with the same demographic characteristics.

HCFA anticipated potential concerns about a risk adjustment methodology based on hospital inpatient data. Such an approach could reward plans that hospitalize patients unnecessarily or, conversely, penalize efficient plans that provide care in other, less costly settings. HCFA has attempted to address these concerns in several ways.

First, PIP-DCG would assign individuals to prior hospitalization categories only when the diagnosis is for a condition that normally requires hospitalization and is linked to further medical costs in the following year. To determine which specific diagnoses to include, HCFA relied on the advice of a clinical panel. The panel recommended that diagnoses associated with about one-third of hospital admissions be excluded because they (1) could be ambiguous, (2) were for conditions that were rarely the main cause for an inpatient stay, or (3) were not good predictors of future health care costs. For example, a beneficiary hospitalized for appendicitis would not be assigned to a higher cost category because that condition generally is not linked to further medical costs in the next year. Also, HCFA's proposal does not permit enhanced payments for hospital diagnoses associated with 1-day stays. These admissions may be more discretionary than admissions for longer stays.

Second, delaying an adjustment in payment until the following year discourages unnecessary hospitalizations that would trigger an enhanced payment. Further, the payment delay dampens any incentive to encourage higher cost enrollees who have been hospitalized to switch plans, since the plan in which the beneficiary is a member the following year receives the payment.

The PIP-DCG method assumes that admission rates for beneficiaries of similar health status are the same for FFS and managed care providers. Although the evidence on managed care admission rates is limited, findings presented by the American Association of Health Plans last month support this hypothesis. A study conducted for the Association found that hospital admission rates for managed care plans and FFS plans were comparable. These findings are consistent with those of a 1993 Mathematica Policy Research study on hospital admissions rates.

Gradual Implementation of Interim Method Will Minimize Impact on Health Plans and Beneficiaries

HCFA proposes to phase in the new interim risk adjustment method slowly. In 2000, only 10 percent of health plans' payments will be based on the new system. This percentage will be increased each year until 2003, when 80 percent of plans' payments will be based on the PIP-DCG risk-adjusted rate. In 2004, HCFA intends to implement a more accurate risk adjuster that uses medical data from physicians' offices, skilled nursing facilities, home health agencies, and other health care settings and providers—in addition to inpatient hospital data.

Although a gradual phase-in of the interim risk adjuster delays the full realization of Medicare savings, it also minimizes potential disruptions for both health plans and beneficiaries. Rapid payment rate changes could strain the financial soundness of some plans. Rapid rate changes could also adversely affect beneficiaries if plans respond by suddenly altering their benefit packages or reconsidering their commitment to the Medicare+Choice program.

If HCFA had comprehensive patient-level data from Medicare managed care plans, it could adjust the PIP-DCG methodology to reflect any differences in practice patterns between managed care and FFS providers. Although plans currently are required to submit only hospital inpatient data, the agency intends to begin collecting more comprehensive data shortly. Therefore, it may be possible to refine the PIP-DCG methodology before the implementation of the full risk adjustment in 2004.

CONCLUSIONS

The implementation of a new health-based risk adjustment system will lead to major changes in Medicare managed care payments and will create more desirable incentives. Plans attracting healthier beneficiaries will be paid less, whereas those attracting costlier beneficiaries will be paid more. In more fairly compensating individual plans for the beneficiaries they enroll, the new method will reduce excess payments and produce savings for taxpayers. The new method represents an interim step in the use of health-based risk adjustment. We believe that to facilitate the introduction of an improved risk adjuster in 2004, plans should aggressively pursue the collection and reporting of more comprehensive data on beneficiaries' medical conditions.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

Related GAO Products

Medicare Managed Care: Payment Rates, Local Fee-for-Service Spending, and Other Factors Affect Plans' Benefit Packages (GAO/HEHS-99-9R, Oct. 9, 1998).

Medicare HMO Institutional Payments: Improved HCFA Oversight, More Recent Cost Data Could Reduce Overpayments (GAO/HEHS-98-153, Sept. 9, 1998).

Medicare HMOs: Setting Payment Rates Through Competitive Bidding (GAO/HEHS-97-154R, June 12, 1997).

Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits (GAO/T-HEHS-97-133, May 19, 1997).

Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

Medicare HMOs: HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of the County Rates (GAO/T-HEHS-97-82, Feb. 27, 1997).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

Medicare: Changes to HMO Rate-Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

Medicare: Health Maintenance Organization Rate-Setting Issues (GAO/HRD-89-46, Jan. 31, 1989).

Mr. BILIRAKIS. Thank you Mr. Scanlon and Dr. Wilensky. Are you both concerned that in some areas of the country risk adjustment may result in more plan withdrawals, on the assumption now that a lot of the withdrawals are due to the forthcoming risk adjustment plan?

Ms. WILENSKY. I am concerned in that this will exacerbate the problem we saw this year. But I think it may be possible to make some changes that will reduce some of the likely that will occur. As I mention in my testimony, part of the concern that we have heard raised is that the Balance Budget Act required the premium benefit combination to be reported in May, which is very early in the year.

And that some of the plans found themselves in a position by mid-summer where their expectations after one quarter were not well met. And that when they attempted to make some adjustments in the early fall, they were unable to do so. One of the recommendations that MedPAC is making is to move that date a little later. We understand it is a tradeoff with making sure that seniors can get their information in a timely way, but 6 months seems a little unduly long as a window.

And that that might help the plans be in a better position to know the premium benefit tradeoffs. Second, we ought to make sure that——

Mr. BILIRAKIS. The July 1, date, I guess, is now the firm date.

Ms. WILENSKY. Yes.

Mr. BILIRAKIS. Are you satisfied that it is——

Ms. WILENSKY. I think the July date was what we were thinking about. I thought that required a statutory change. So it maybe what has been agreed to informally, but I don't know that. But if that would go through, I think that would be a good improvement. The second thing is whether the quality requirements are appropriate to the needs. In having been in that place, I have sympathy with the interest and need for information. Making sure that the requirements are not too burdensome and too costly is something that ought to have some oversight.

And ultimately whether or not the payment is right. Particularly the 95 percent after the full phase in of risk adjustment I think would also be an appropriate reconsideration. None of those, in my view, alters the appropriateness of risk adjustment. It is a problem.

You heard, Mr. Waxman, Mr. Brown, all of you on the committees, discussing why having appropriate adjustments for the health status should be considered as a part of the plan.

I urge you not to try to fix one problem by altering the solution of another.

Mr. SCANLON. We share the concern about the withdrawals of plans and the reductions in service areas in different portions of the country. And certainly the change in the rates may be a factor. However, in looking at participation of plans in the past, we discovered that rates alone are not the sole determinate of how much managed care penetration there is in an area.

We have low rate areas of this country in which there was very extensive managed care participation on the part of Medicare beneficiaries in part because there was strong participation among non-Medicare, younger individuals in managed care. As Dr. Wilensky indicated, there has been a series of changes that have occurred recently with respect to managed care participation. The fact that the volume and the speed with which the changes have occurred is a major factor in plans perhaps assessing their participation. This may be a short term phenomenon.

We are doing work for this committee as well as for the Committee on Ways and Means and the Senate Finance Committee looking at the change in plans' participation and we will try to identify, to the extent possible, how different factors have played a role in affecting participation now. But I would also emphasize that we are potentially in a period of transition.

In some respects the terms under which Medicare is purchasing managed care have changed and managed care plans have to assess whether or not they can provide care, under those terms. But frankly, they have been changed in ways that we have talked about over the years that are positive from the program's perspective.

These changes involve trying to align payment appropriately and making sure that we have accountability for the care that we purchase.

Mr. BILIRAKIS. How close are you, Mr. Scanlon, to definitizing the reasons why——

Mr. SCANLON. We are hoping to report to you by the end of next month.

Mr. BILIRAKIS. By the end of March.

Mr. SCANLON. Right.

Mr. BILIRAKIS. Okay, now I guess you are doing that for Ways and Means now?

Mr. SCANLON. We are doing it for you, Ways and Means and Finance.

Mr. BILIRAKIS. Okay.

Mr. SCANLON. All three committees, all three authorizing committees.

Mr. BILIRAKIS. Well that is, I think significant.

Ms. WILENSKY. Mr. Bilirakis, MedPAC is also attempting to monitor the counties in which change is occurring, withdrawal occurring. And as part of our June Report we will have whatever information is available to us. What has happened and any information we have as to why there has been withdrawals and the effect that it has had on the beneficiaries' access to health care plans.

Mr. BILIRAKIS. We have had counties where there have been withdrawals, but in many of those counties there are other options.

Ms. WILENSKY. Most of the counties.

Mr. BILIRAKIS. Under the fee-for-service. Most of those counties, yes.

Ms. WILENSKY. Right.

Mr. BILIRAKIS. But there are some counties where there aren't any other options and that is significant information. Was that information requested of Mr. Hash? We have a break down by county and we have the total. For instance, in Florida, 58,571 enrollees are affected. But only 8,271, as I read this chart, are affected so adversely that there aren't any other choices.

So, there is no breakdown of that 8,271 by county so that we can have some idea. I don't know——

Ms. WILENSKY. HCFA would have that information. It is available by county.

Mr. BILIRAKIS. Is HCFA still here? All right, can we request that information from you as soon as you can get it? And since you have already broken out the 8,271, you must have that by county, I would think? Good. If you could submit that to us, I would appreciate it. All right, thank you. Mr. Brown.

[The following was received for the record:]

Plans that Left Medicare or Reduced Their Service Area: Counties with No Other Managed Care Option

(as of the contract year beginning January 1, 1999)

State	County Name	Contract Name	Non-Renew or Service Area Reduction	AAPCC	Eligibles	#Benes Enrolled
California	Colusa	Health Net CA	SAR	$514.42	2,557	209
California	Glenn	Health Net CA	SAR	$452.95	4,155	483
California	Inyo	Cigna S. CA	SAR	$419.87	3,916	162
California	Lassen	National Med, Inc	Non-Renew	$435.79	3,929	2
California	Modoc	National Med, Inc	Non-Renew	$401.19	1,760	23
California	Mono	Cigna S. CA	SAR	$422.10	812	7
California	Monterey	Pacificare N. CA	SAR	$493.50	43,324	4,325
California	Plumas	Health Net CA	SAR	$517.82	3,996	63
California	Shasta	National Med, Inc	Non-Renew	$490.85	30,917	1,088
California	Sierra	Health Net CA	SAR	$454.96	710	18
California	Siskiyou	National Med, Inc	Non-Renew	$412.28	9,761	275
California Total					**105,837**	**6,655**
Delaware	Kent	Aetna—Del	Non-Renew	$411.14	15,892	760
Delaware	Kent	AmeriHealth HMO	Non-Renew	$411.14	15,892	263
Delaware	Kent	Optimum Choice	Non-Renew	$411.14	15,892	29
Delaware	Sussex	Aetna—Del	Non-Renew	$463.82	29,931	1,072
Delaware	Sussex	AmeriHealth HMO	Non-Renew	$463.82	29,931	869
Delaware	Sussex	Optimum Choice	Non-Renew	$463.82	29,931	379
Delaware Total					**59,862**	**3,372**
Florida	Citrus	AvMed	SAR	$463.64	35,278	1,391
Florida	Gilchrist	AvMed	SAR	$476.67	2,031	409
Florida	Glades	Humana Medical Plan, S. FL	SAR	$580.75	923	138
Florida	Hendry	Humana Medical Plan, S. FL	SAR	$509.16	3,587	747
Florida	Highlands	Humana/PCA	SAR	$460.03	25,776	1,218
Florida	Highlands	United Health Care FL	SAR	$460.03	25,776	172
Florida	Marion	AvMed	SAR	$426.12	66,282	3,866
Florida	Monroe	Humana Medical Plan, S. FL	SAR	$605.18	11,437	1,234
Florida	Okeechobee	Humana Medical Plan, S. FL	SAR	$720.81	6,845	1,970
Florida	Polk	Aetna—FL	SAR	$397.97	90,138	1,638
Florida	Polk	Florida First Health Plans, Inc	Non-Renew	$397.97	90,138	0
Florida	Polk	Humana/PCA	SAR	$397.97	90,138	169

Plans that Left Medicare or Reduced Their Service Area: Counties with No Other Managed Care Option—Continued

(as of the contract year beginning January 1, 1999)

State	County Name	Contract Name	Non-Renew or Service Area Reduction	AAPCC	Eligibles	#Benes Enrolled
Florida	Polk	United Health Care FL	SAR	$397.97	90,138	565
Florida	Polk	CIGNA	SAR	$397.97	90,138	10
Florida Total					**242,297**	**13,527**
Kentucky	Carroll	Southeastern United Medigroup ..	SAR	$419.61	1,649	0
Kentucky	Gallatin	Southeastern United Medigroup ..	SAR	$427.91	919	0
Kentucky	Grant	Southeastern United Medigroup ..	SAR	$442.00	2,962	0
Kentucky	Hardin	Southeastern United Medigroup ..	SAR	$506.02	10,965	0
Kentucky	Henry	Southeastern United Medigroup ..	SAR	$466.06	2,481	0
Kentucky	Meade	Southeastern United Medigroup ..	SAR	$508.52	2,198	0
Kentucky	Owen	Southeastern United Medigroup ..	SAR	$379.84	1,332	0
Kentucky	Shelby	Southeastern United Medigroup ..	SAR	$393.88	3,837	0
Kentucky	Spencer	Southeastern United Medigroup ..	SAR	$449.11	1,212	0
Kentucky	Trimble	Southeastern United Medigroup ..	SAR	$494.58	1,064	0
Kentucky Total					**28,619**	**0**
Missouri	Gasconade	Group Health Plan	SAR	$379.84	3,270	90
Missouri	Montgomery	Group Health Plan	SAR	$400.08	2,412	34
Missouri Total					**5,682**	**124**
Minnesota	Goodhue	Medica Minn	SAR	$379.84	7,170	72
Minnesota Total					**7,170**	**72**
New Hampshire	Strafford	Aetna—NH	Non-Renew	$406.83	14,391	187
New Hampshire Total.					**14,391**	**187**
New York	Broome	Welicare	SAR	$379.84	39,143	2,021
New York	Broome	Community Health Plan	Non-Renew	$379.84	39,143	2,761
New York	Tioga	Community Health Plan	Non-Renew	$379.84	7,431	364
New York Total					**46,574**	**5,146**
North Dakota	McLean	Blue Cross & Blue Shield of North Dakota.	Non-Renew	$379.84	2,217	3
North Dakota	Mountrail	Blue Cross & Blue Shield of North Dakota.	Non-Renew	$379.84	1,351	0
North Dakota	Renville	Blue Cross & Blue Shield of North Dakota.	Non-Renew	$379.84	573	0
North Dakota	Ward	Blue Cross & Blue Shield of North Dakota.	Non-Renew	$387.06	8,337	9
North Dakota Total					**12,478**	**12**
Ohio	Coshocton	Community Insurance OH	SAR	$413.89	6,155	692
Ohio	Coshocton	Community Health OH	SAR	$413.89	6,155	0
Ohio	Muskingum	Community Health OH	SAR	$394.85	14,840	2
Ohio Total					**20,995**	**694**
Oregon	Hood River	Qualmed Oregon	Non-Renew	$379.84	2,743	258
Oregon	Lincoln	Qualmed Oregon	Non-Renew	$379.84	9,925	121
Oregon	Wasco	Qualmed Oregon	Non-Renew	$379.84	4,408	149
Oregon Total					**17,076**	**528**
Texas	Freestone	Pacificare TX	SAR	$379.84	2,922	77
Texas	Karnes	PCA TX	Non-Renew	$379.84	2,566	2
Texas	Limestone	Humana TX	SAR	$379.84	4,371	5
Texas	Mc Lennan	Humana TX	SAR	$379.84	30,779	11
Texas	Navarro	Pacificare TX	SAR	$417.42	7,613	392
Texas	Wilson	Humana TX	SAR	$401.27	3,511	159
Texas Total					**51,762**	**646**
Utah	Davis	IHC Utah	Non-Renew	$379.84	17,475	587
Utah	Davis	Pacificare Utah	Non-Renew	$379.84	17,475	645
Utah	Morgan	IHC Utah	Non-Renew	$419.37	615	31
Utah	Morgan	Pacificare Utah	Non-Renew	$419.37	615	9
Utah	Salt Lake	IHC Utah	Non-Renew	$381.21	80,489	5,229
Utah	Salt Lake	Pacificare Utah	Non-Renew	$381.21	80,489	7,447
Utah	Summit	Pacificare Utah	Non-Renew	$379.84	1,449	97
Utah	Tooele	Pacificare Utah	Non-Renew	$418.57	3,013	139
Utah	Utah	Pacificare Utah	Non-Renew	$382.96	25,599	2,383
Utah	Wasatch	Pacificare Utah	Non-Renew	$379.84	1,324	61

Plans that Left Medicare or Reduced Their Service Area: Counties with No Other Managed Care Option—Continued

(as of the contract year beginning January 1, 1999)

State	County Name	Contract Name	Non-Renew or Service Area Reduction	AAPCC	Eligibles	#Benes Enrolled
Utah	Weber	IHC Utah	Non-Renew	$379.84	22,299	1,009
Utah	Weber	Pacificare Utah	Non-Renew	$379.84	22,299	925
Utah Total					**152,263**	**18,562**
Virginia	Albemarle	QualChoice VA	Non-Renew	$413.51	8,177	208
Virginia	Buckingham	QualChoice VA	Non-Renew	$418.45	2,045	3
Virginia	Caroline	NYLCare—MDNA/DC	Non-Renew	$433.45	3,032	106
Virginia	Charlottesville City.	QualChoice VA	Non-Renew	$410.17	7,253	187
Virginia	Fauquier	NYLCare—MDNA/DC	Non-Renew	$424.54	5,885	347
Virginia	Fluvanna	QualChoice VA	Non-Renew	$437.79	2,866	71
Virginia	Fredericksburg City.	NYLCare—MDNA/DC	Non-Renew	$453.99	8,080	239
Virginia	Greene	QualChoice VA	Non-Renew	$440.94	1,567	37
Virginia	King George	NYLCare—MDNA/DC	Non-Renew	$432.61	1,688	25
Virginia	Louisa	NYLCare—MDNA/DC	Non-Renew	$456.03	3,626	47
Virginia	Louisa	QualChoice VA	Non-Renew	$456.03	3,626	50
Virginia	Madison	QualChoice VA	Non-Renew	$387.38	1,861	25
Virginia	Nelson	QualChoice VA	Non-Renew	$409.42	2,990	34
Virginia	Orange	QualChoice VA	Non-Renew	$414.43	5,301	50
Virginia	Richmond	NYLCare—MDNA/DC	Non-Renew	$425.76	790	0
Virginia	Spotsylvania	NYLCare—MDNA/DC	Non-Renew	$452.25	3,917	102
Virginia	Stafford	NYLCare—MDNA/DC	Non-Renew	$457.11	4,069	157
Virginia	Westmoreland	NYLCare—MDNA/DC	Non-Renew	$484.77	3,344	63
Virginia Total					**66,491**	**1,751**
West Virginia	Monongalia	HealthAmerica	SAR	$502.11	9,711	0
West Virginia Total					**9,711**	**0**
Total for All States					**841,208**	**51,276**

Source: HCFA 12/98

Mr. BROWN. Thank you, Mr. Chairman. Dr. Wilensky, thank you for joining us. Without risk adjustment a plan with sicker than average enrollees that offers high quality benefits can lose money. A competing plan with healthier than average enrollees offering the same high quality benefits could prosper and make money. Can such a system work without risk adjustment?

Ms. WILENSKY. Not for very long. You run the risk of inappropriately rewarding plans because of their selection and inappropriately hurting plans because of either their intentional or unlucky attraction of sick people. If you are going to appropriately reward and incent plans for taking on sick people and giving sick people an option of having coordinated care as a replacement for Medicare, you need to make this adjustment.

If you don't get into trouble without making an adjustment, it is just because you are lucky. The incentives are there to get yourself in trouble. A very important step, it has been discussed for many years, and HCFA is starting what I think is a reasonable process.

Mr. BROWN. So Medicare managed care really can't work without risk adjustment.

Ms. WILENSKY. What you may end up doing is having a health care plan that contracts with an academic health center or a very well-known health foundation or health care provider that itself attracts very sick people finding itself disadvantaged relative to a health care plan that didn't have such arrangements. That is not

a very good idea in terms of rewarding one and penalizing the other.

It is not just Medicare/managed care. It is actually any kind of replacement Medicare plan. If you allowed for private fee-for-service, which you actually did as part of the Balanced Budget Act, you need to have risk adjustment any time there is a choice of a health care plan. It is very similar to why you have a classification system for paying hospitals.

If you paid hospitals the same amount, given somebody's age, and didn't make any kind of adjustment for the diagnosis, you would obviously overpay hospitals that admitted people with relatively minor health conditions. And you would underpay them if they had by-pass surgery or valve replacement, et cetera. This is really the same kind of adjustment. You acknowledge that health status will predictably influence a patient's use of expenditures and it is the predictable difference that you try to compensate for.

Mr. BROWN. Mr. Scanlon, we have been hearing that HCFA should wait to implement risk adjustment until we have a better, a more complete set of data to incorporate into it. Now given HCFA's historic overpayment to managed care plans, I assume waiting to implement risk adjustment will cost the Medicare Program a lot of money.

Do you have an idea how much HCFA will lose if risk adjustments, say, were delayed for 2 years?

Mr. SCANLON. The estimate of overpayment made by Physician Patient Review Commission was $2 billion. A risk adjuster, however, is not going to eliminate all of that overpayment. It is only going to eliminate a fraction. My understanding of HCFA's estimate of the cost through the transition is that it is roughly $1.4 billion, I think, that is going to be lost due to phasing this in as opposed to immediately implementing it.

So it is somewhere in that ball park, I think, per year that we are talking about. We defer to HCFA on more precise numbers for that.

Mr. BROWN. Okay, thank you. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Mr. Whitfield.

Mr. WHITFIELD. Thank you, Mr. Chairman. Dr. Wilensky and Mr. Scanlon, do we have any reason to anticipate that as a result of this risk adjustment approach that some health maintenance organizations may become more specialized or make an effort to focus more on the treatment of seriously ill Medicare patients? And then from that, because of the efficiency and quality just make that sort of a specialty that they would have of treating those kinds of patients?

Ms. WILENSKY. Well, we would like to assume we could get there. I think in the beginning the adjustment probably isn't all that good that you would want to make that your overwhelming specialty. But as we get better in making risk adjustments, it certainly should allow plans that want to attract physicians and other health care providers that treat seriously ill patients to do so and not feel that they will be penalized. And that would not be the case now.

If you had a health care plan that specialized in the treatment of AIDS patients or diabetics with multiple complications, they would be hurt by our payment system.

Mr. SCANLON. I would agree. I think that we have seen in the experience of the Medicaid Program which has somewhat more experience with risk adjustment that it does alleviate some of the concerns of plans that might include within their networks a specialty center, like an academic medical center or a cancer center or a group of physicians who provide care for people with AIDS.

Because without risk adjustment, many plans are fearful of having those types of providers in their network, feeling that they will attract a disproportionate number of people with very high cost illnesses. With risk adjustment, more of these providers end up potentially in networks. That is a very positive. But I agree also that it will take awhile before we may see a plan that specializes in providing such care.

Mr. WHITFIELD. And would there be any regulations or current laws on the books that would prohibit an entity from pursuing that. I mean, in other words could they say, well, we are not going to take this Medicare patient because we want this one?

Ms. WILENSKY. No. It is not legal to make that kind of selection. But you can indirectly influence who you are attractive to by which groups of physicians or what hospitals you contract with. If you contract with a cancer hospital or you contract with an academic health center, particularly one that specializes in certain complicated treatments, you are going to be very attractive to sick people.

If you contract only with community hospitals that do little of tertiary, quertesary medicine, you will be less attractive. So there are ways to make it more or less attractive.

Mr. WHITFIELD. It seems to me that over the long term that would be a positive benefit if you do have organizations that really are specializing in particular areas. Would you all agree with that?

Ms. WILENSKY. I agree. Whether or not that happens will depend on whether or not we will have a risk adjustment system that does that. An idea that the Vice Chair of MedPAC, Joe Newhouse, has raised is to try to make sure very sick patients continue to be attracted to plans through something called partial capitation, where a portion of the payment that would go to the plan would reflect actual use.

So that you would have maybe 20 percent of the payment for the person reflect the actual use and 80 percent being a health adjusted risk payment, just to make sure that the very sickest, who use a lot of resources, aren't shunned by health care plans. I think it would be much better if we had opportunities for very sick people to have their care better coordinated than exists under current Medicare.

Mr. WHITFIELD. I yield back the balance of my time.

Mr. BILIRAKIS. Mr Waxman, inquiries.

Mr. WAXMAN. Thank you, Mr. Chairman, I appreciate the testimony from both our witnesses. Both of you believe we ought to try to develop a risk adjustment in order to make the Medicare+Choice System work. HCFA is starting off looking at in-patient information. They are hoping to get more data on out-patient. They are going to have 1 year and try to learn from that year to extrapolate to the next. This is not easy work, is it, to develop a risk adjuster?

Ms. WILENSKY. No. They have been sponsoring research for at least 10 years.

Mr. WAXMAN. Does that give you some caution about moving forward with changes that put more weight on a risk adjustment working pretty well?

Ms. WILENSKY. Well, I think what HCFA has done by the phase in and by the backwaiting of change, is a reasonable way to minimize disruptions and to have the biggest impact occur when you should expect to have better data. One of the things that happens when you introduce change is that you typically get better just by doing it, which is one of the reasons I am eager to have them start.

Mr. WAXMAN. Mr. Scanlon, I would like your response to that question, and let me put it differently. Government is not the best in accomplishing management of very complicated systems. And now we are going to have government involved in a very major way to make adjustments between plans as to the severity of the illnesses of the population and a lot of other factors. This is complicated business.

Do you feel some sense that we ought to recognize that while we would like to have risk adjustment, we may not achieve one that works real well for some time, and therefore we ought to be a little bit careful in moving in a direction where we expect it to work very well?

Mr. SCANLON. Well, I think we should be extremely careful to make sure that it works as well as we possibly can. But the reality is we already have risk adjustment. We have a risk adjustment system that is based on demographic characteristics and whether someone is Medicaid eligible and whether someone is in an institution and whether someone is eligible because they are either aged or disabled.

It is not working. Those factors explain about 1 percent of the variation in medical costs. The hospital-based system is going to explain about 5 percent of the variation in medical cost. It is an improvement; it is not a solution. An all encounter system is going to continue to improve this share of medical cost variation that we can explain.

So I think that we really do need to push for moving toward that better system. The phasing period here is critical. We have seen HCFA as backloading the system. In this first year, we are only going to adjust the cost by blending a 10-percent base on the new risk adjuster and 90 percent based on the old.

Mr. WAXMAN. Let me interrupt you because I have limited time. I don't disagree with your testimony, that we need a risk adjuster. What I am trying to figure out is how Mr. Bilirakis and Mr. Dingell and others sitting on this Medicare Reform Panel make a judgment when they are looking at the notion of premium support, and the idea of a premium support is predicated on plans coming in and bidding, and then basing the premium contribution on some percentage of the average of all the bids.

Unless we have a real good risk adjuster that works, we still have a good chance that some plans are going to be able to bid very low because they are still, in lots of clever ways, able to select out a patient population that is a lower risk. And insofar as we have some plans able to bid low, that is going to pull the average down.

So if we have a percent of an average premium that we are going to say to people we'll contribute for their Medicare selection, then those who are sicker and older and maybe less prosperous, are going to have to come up with a lot more money if they go into a plan that takes care of them.

I don't know if Mr. Whitfield was suggesting that some plans might find it advantageous to take more sick people. I don't think it is ever going to be advantageous to have to spend more money on a capitated population. So my concern is if people have to go into a plan that is going to spend more money, they are going to have to come up with a lot of money out of pocket in order to be in that plan or be forced into whatever may be available to them.

So I am just worried that unless we know a risk adjustment works, then we ought to be cautious about leaping into a whole new system.

Mr. SCANLON. I don't think we have made a leap in this situation.

Mr. WAXMAN. I am not talking about what we are doing now, I am talking about what the Commission is talking about.

Mr. SCANLON. Right. And there is no question about what we want——

Mr. WAXMAN. To move to enhance premium or premium support or whatever they call it.

Mr. SCANLON. The more we rely on the risk adjuster the better risk adjusters we need. I think that during this transition period, we need to learn from this experience. We have been learning about risk adjusters from the experience of the Medicaid Program, from some experience in the private sector. This is really Medicare's first attempt to try and do something that is health-based.

Mr. WAXMAN. My time is up. We have been researching this for 10 years. You say the more experience we have with a risk adjuster, the better we will be. I am just saying, we are not there yet where we can say we know what really works. I want to be sure that if we move into a whole new system of premium support that we don't act as if we had a risk adjustment that was working so well that we are not going to leave a lot of people and plans in the lurch.

Mr. SCANLON. I am not going to say that your concern is not valid. But I would say we have been researching it for 10 years, now we need to be using it and see if we can learn from the use of it.

Mr. WAXMAN. While we are using it a lot of plans are closing their doors.

Mr. SCANLON. Well, we are hoping that is not the full story there.

Mr. BILIRAKIS. Mr. Shadegg.

Mr. SHADEGG. Thank you, Mr. Chairman. I will be brief. I think I heard you just say that we have, in reality, a risk adjuster no matter what, it already exists. This one wasn't studied or calculated very well. We are now working on trying to study and calculate a new one. And in that regard let me ask, particularly you, Mrs. Wilensky, but Mr. Scanlon if you want to comment I would be interested in that as well.

The risk adjuster currently being used focuses on in-patient hospital data. It is clear the law requires that in the first year, but then is not so clear as to the remaining years, yet it appears HCFA is going to look at in-patient data for all, for four of the 5 years. I guess I am interested in what information we will not capture by looking at in-patient data. And what the affect of that might be and what you think we should be looking at?

Ms. WILENSKY. Well, there is no question that there is an irony about using in-patient only data to adjust payments to risk-based plans. They have spent their whole being trying to alter the in-patient/out-patient mix of services to use more out-patient, not to rely on in-patient. And so there clearly is an irony about having that happen.

However, HCFA has attempted to mitigate the problems by not looking at discretionary in-patient stays. By not looking at 1-day stays. Although that could go either way. And by moving as quickly as they feel possible to full encounter data. If it is possible to get to full encounter data by year 3, that would be much better. The sooner the better. And the fact that you are backloading it, helps some.

It is not, by any means, a perfect way to go, but I think starting the process will help. And moving as fast as humanly possible, even if you don't have full encounter data, to encounter data for most plans would be a worthwhile tradeoff. I would also like to just comment on the discussion we were having about the complexity. It is true this will make it more complex, but remember relative to what?

We have a Medicare Plan where government is involved in deciding 9,000 CPT Codes and 500 Admission Codes and a number of post-acute payment rates. So it is a very complicated system that we have. If we can make adjustments so that we give sick people a chance to have a different kind of health care plan, I think it is really worth pushing on. So I think you can mitigate some of the concerns about in-patient only. But it is a fair issue.

Mr. SHADEGG. Mr. Scanlon.

Mr. SCANLON. We share the same views as Dr. Wilensky in terms of this not being a perfect system. There is a lot of the variation in medical costs that will not be recognized. Pushing forward is the key here as is trying, during this transition period, to accelerate what we know and whether or not adjustments are needed.

Mr. SHADEGG. I guess I would only conclude by saying, with regard to the question of going forward with the risk adjuster about which we do not have perfect knowledge is probably true that on a few occasions government has passed legislation without knowing all of their unintended consequences. Mr. Chairman, I yield back.

Ms. WILENSKY. Even in Medicare.

Mr. SHADEGG. I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Barrett to inquire, sir.

Mr. BARRETT. Thank you, Mr. Chairman. Mr. Scanlon, have you been surprised, you talked about plans dropping out. Have you been surprised by the number of providers that have dropped out?

Mr. SCANLON. We have been somewhat surprised but not totally. We have made a significant number of changes to what is to be a managed care plan within the Medicare Program. We saw in the

mid 1980's, a similar sort of high level of withdrawals as plans were learning to be able to serve elderly beneficiaries, and some were finding that this was more difficult than they originally thought. And then after enrolling they decided to sort of leave Medicare.

My sense is that what we will see is that some of those same plans that chose to leave will come back into some areas, but not necessarily into others. The market for managed care, frankly, is in some turmoil today that didn't exist a few years ago. We had a period of very low inflation. We are not seeing premiums going up. We have managed care plans reassessing their ability to serve, not just Medicare, but as Mr. Hash indicated, FEHBP beneficiaries and changing the terms that they are willing to provide private employers.

So I think that all of these things are going on. It is very hard to sort out what the lessons are from something that is in this much turmoil, but we are trying to do it to the extent we can now. I do think we need to be cautious about changing our direction which is sound in the sense that we feel that Medicare is moving toward paying more appropriately and asking for accountability on what is being purchased.

Mr. BARRETT. Same question, Dr. Wilensky?

Ms. WILENSKY. I was surprised, although I think part of the change, the drop out, didn't have to occur if HCFA had behaved more like an Insurance Commissioner. Allow plans to come in, beat them up, give them 15 or 20 percent of what they asked for in terms of their second round of change, and we might have forestalled some of the withdrawal.

Part of it was some bad decisions on the part of some plans to go into areas where they had too little infrastructure. It may also have been a problem that plans used to think about a zero premium or a very small premium, but I think now they are looking at a competitive Medigap alternative which is frequently $1,800 a year.

And so it may well be possible to offer an attractive package with a premium that is $30 or $50 a month more than they had been offering. More than they would have been charging before. But far less for a full package of Medigap benefits than is available as the alternative. So I think there may have been some learning going on. There may have been some bad expectations by the plans and by seniors. And the plans may have made some strategic errors in terms of how rapidly they went out into some of the areas.

But I am concerned. I think we have to watch what is going on. It may be that some of the requirements have raised too much uncertainty, but I don't think risk adjustment is the place to stop. That is a very important change.

Mr. BARRETT. Were the decisions to pull out exclusively economic decisions?

Ms. WILENSKY. Well my sense is—and I know you have panels later from the health care plans who can tell you more—that plans were quite reluctant to pull out. It is bad publicity, it doesn't sit well. Most of these plans didn't leave entirely. They left some markets. At least most of the big companies stayed in Medicare in some markets and left in other markets.

My sense is that they were concerned that not only were they losing money, or not making money in some markets, but they had high degrees of uncertainty about whether things were going to get better in the near term. In fact, some sensed that they were much more likely to be hurt even more. And on those grounds, they left the areas. I think it is economic, but not as little as saying, we weren't making enough money.

I think there was a sense that this is not something you want to do. But if they didn't do it this year, there is a 5-year stay out period. So it was less costly to do it now than it will be in the future. That will be a much bigger decision.

Mr. BARRETT. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Barrett. Well, the fact is that, the many, some plans are withdrawing. The fact is that they are withdrawing in some areas where there are no other choices other than going back to fee-for-service, which is very difficult for some people because of their reasons for going to managed care in the first place. Prescription drugs principally, I guess.

Now you have mentioned, Dr. Wilensky, that possibly taking a look at the reimbursement rates in some areas and what not, and the staff and I have talked and they have mentioned that too. I guess the first thought that comes to my mind is would this be maybe rewarding some, you mentioned bad public relations and the fact that they didn't very rashly withdraw, but they really were reluctant to withdraw. And I will accept that. But could this be rewarding some people maybe who should not have withdrawn?

Ms. WILENSKY. I think you need to know more about what happened and why it happened and what is likely to happen in the future. MedPAC is very concerned about this. We are going to monitor it. We think you need to monitor it. I don't think any of us understand enough about what is going on to say throw more money at the problem. We ought to look at the additional costs that we are imposing on plans and we ought to be careful about what happens in the future.

But I don't think there is evidence to date to suggest go in and put more money to fix the problem.

Mr. BILIRAKIS. Is there something else that could be done, maybe, whether it be in addition to that or lieu thereof in some cases the data that is, how onerous is this data gathering?

Ms. WILENSKY. Well, I think that is an issue that, and it may be one that GAO either has or could look at, which is the data that are being required to be reported under the HCFA rules. Whether it is as lean and as cost-effective a requirement as possible, whether there are some ways to lighten that burden. And perhaps along with changing the date of the ACR reporting, that might be able to keep some plans in. And encouraging a little more dialog between HCFA and some of the health care plans, although I know that they engage in that.

It is important to have these options out there. It is not obvious why you should have seen so much change early on. I am surprised. Ultimately there is a problem that in the high spending areas where there have been a lot of health care plans, the slow growth in the capitation payment is going to mean a big divergence between what traditional Medicare spends in some of the south

Florida counties and some of the California counties and what the capitation plans get as their capitation rate.

And that is a mistake. That differential payment will continue because traditional Medicare is going to be growing at 5 or 6 percent per year, per capita payments in these areas are probably going to grow at the minimum of 2 percent per year. And you are going to have to go back and try and get those in alignment. That is probably the one thing you can plan on having to take up in the next year or 2. Right now I don't think we know much more than that. But perhaps Bill would comment.

Mr. SCANLON. I think we do need to be very concerned about what it is that we have asked the plans to do in terms of the reasonableness of the burden for participation. But at the same time, we maybe also need to focus on whether or not the basic premise that we are using, not just for the managed care portion of Medicare but with respect to many services as well. We have built our payment methods on national averages.

What we have seen are withdrawals in certain areas and not within others. We need maybe to ask ourselves, do we need a different but still rational basis upon which to base payment. It may be that we do. Participation levels over the longer haul may be an indicator that more regionalization is important. A similar kind of concern may arise in the future with respect to physicians, who have also experienced very significant changes in the payments that they are receiving.

Ultimately, we need to think about our philosophy about setting rates more generally rather than just for the Medicare managed care program.

Mr. BILIRAKIS. Thank you. Mr. Brown? Mr. Barrett? Thanks so very much. We appreciate your patience and your willingness to help out. The next panel. Ann Miller, Member of the Board of Directors of AARP and Diane Archer, Director of the Medicare Rights Center. Oh, I am sorry, I didn't mean to leave out Ms. Wegner. Nona Wegner, Senior Vice President of the Seniors Coalition. We had the pleasure of her company just recently before this committee.

Your written testimony is a part of the record. We would prefer that you would complement it orally. We will set the clock at 5 minutes and hopefully you will stay as close to it as you possibly can.

Ms. Miller.

STATEMENTS OF ANN MILLER, MEMBER, AARP BOARD OF DIRECTORS; DIANE ARCHER, EXECUTIVE DIRECTOR, MEDICARE RIGHTS CENTER; AND NONA BEAR WEGNER, SENIOR VICE PRESIDENT, THE SENIORS COALITION

Ms. MILLER. I am Ann Miller from Morro Bay, California. I am a Member of the AARP's Board of Directors. In 1997, AARP supported the BBA and its creation of Medicare+Choice. I am pleased to be here today to present AARP's views on Medicare+Choice, the risk adjuster and other reform issues. Medicare+Choice was enacted to expand the health care options available to Medicare beneficiaries while at the same time maintaining affordable, quality care in Medicare.

Last fall's unexpected disruption in Medicare HMO availability, illustrates the magnitude of these changes and holds several lessons. First, while private sector options have been able to address some glaring faults in original Medicare, such as the lack of prescription drug coverage and high out-of-pocket costs, these options are not without their own shortcomings.

A private business can be more innovative and efficient. But if it is not profitable, it will leave the market. Therefore, private market participation in Medicare must be structured to assure beneficiaries have stability in their health insurance coverage. Second, the impact of the BBA has been and will continue to be significant. It must be evaluated and understood before launching even a greater Medicare Reform.

The Medicare HMO withdrawals last year displaced about 400,000 Medicare beneficiaries from their HMO's. This unexpected event created a lot of confusion and frustration as beneficiaries struggled to find alternative HMO's or returned to original Medicare. The HMO industry contends that the BBA payment methodology was the chief reason that plans pulled out of certain markets. AARP does not have enough data to evaluate whether or not payments are adequate or fairly calculated, but such claims should be carefully reviewed to ensure that we don't return to the error of overpayments to some plans.

We believe it is important for Congress, the Medicare Commission, HCFA, health plans and beneficiaries to understand what caused last year's withdrawals. In order to determine how to preserve enrollment stability for beneficiaries without undermining the physical integrity of the program. Health plans have also reported that uncertainty about risk adjustment contributed to their decisions to pull out of certain markets in 1998, and that could lead to future withdrawals.

While we understand that the methods of risk adjustment are imperfect, it is important that HCFA move forward by phasing in the proposed risk adjuster to allow a smooth transition to more accurate payments for plans. The proposed phase in will soften the economic impact on plans while implementing at least a partial solution. Another important issue is the Medicare Beneficiaries Education Campaign.

Medicare+Choice can realize its potential only if beneficiaries have the knowledge that will enable them to be wise consumers in the market place. We support HCFA's efforts to educate beneficiaries and as a part of our effort to make Medicare+Choice work, AARP has a campaign to educate our members about Medicare+Choice. Congress must also do its part by providing sufficient resources so HCFA can carry out this challenging task.

And we strongly support increasing Medicare+Choice user fees to $150 million. This increase is needed to assure that all aspects of the education campaign can be carried out as Congress envisioned. I want to emphasize the importance of fully understanding the changes that have already been made under Medicare+Choice before we layer on new changes.

Let me assure you, however, that AARP does not believe that the status quo in Medicare is acceptable. More must be done to assure the program's long term solvency and prepare Medicare for the re-

tirement of the baby boomers. There are some fundamental principles that have guided Medicare, which AARP believes should be the basis of any efforts to reform the program. I want just to highlight a few.

Medicare should continue to be available to all older and disabled Americans despite health status or income. It should guarantee a defined set of benefits with payments that keep pace with the cost of the benefit package. Medicare should keep up the advances in medicine. This means, among other things, including prescription drug coverage in the Medicare benefit package. And changes in Medicare financing and benefits should protect all beneficiaries, including those with low incomes, from burdensome out-of-pocket costs.

AARP looks forward to continue to work with this committee and your colleagues in the House and Senate on a bi-partisan basis to improve on the Medicare+Choice Program. We also want to work with you to advance a Medicare Reform Package. The status quo in Medicare is not acceptable. But together we must ensure that any reform package continues Medicare's promise of quality, affordable health care. Thank you.

[The prepared statement of Ann Miller follows.]

PREPARED STATEMENT OF ANN MILLER, MEMBER, AARP BOARD OF DIRECTORS

Good morning Mr. Chairman and members of the Committee. I am Ann Miller from Morro Bay, California. I am a member of the AARP Board of Directors and come before you as a representative of a group whose large and diverse membership includes millions of current and future Medicare beneficiaries. The Association supported the creation of the Medicare+Choice program as part of the Balanced Budget Agreement in 1997 and we appreciate this opportunity to share the beneficiary perspective on the Medicare+Choice program today.

In 1997, Congress passed the Balanced Budget Act (BBA) that included sweeping changes in the Medicare program. The BBA provided significant program savings to extend Medicare's solvency until 2008 and made several major changes affecting the program's beneficiaries. These changes included the creation of the Medicare+Choice program through which four new health plan options are to become available to beneficiaries. The legislation also addressed when and how beneficiaries can enroll in health plans or Medigap plans, as well as what information beneficiaries receive about those choices. In addition, as the changes mandated by the BBA take effect, virtually every beneficiary will face higher out-of-pocket expenses for health care.

AARP supported the BBA and its creation of Medicare+Choice in order to accomplish the objective of expanding choice in the program while also protecting access, affordability, and quality. We understood that extending the short term solvency of the Medicare program required shared sacrifice from all who participate in the program—providers and beneficiaries alike. We also recognized that Medicare+Choice would lay the foundation for essential longer term reform in the Medicare program.

Impact of BBA

Last fall's unexpected disruption in Medicare HMO availability, however, serves as a wake-up call to all who seek to bring private sector solutions to bear on Medicare's problems. While private sector options have been able to remedy some glaring faults in original Medicare, such as the lack of prescription drug coverage and high out-of-pocket costs, these options are not without their own failings. When private businesses are given the right to manage a beneficiary's care in exchange for the opportunity to earn a profit, several things can happen. On the plus side, the innovations in administrative efficiency and improved health care delivery could benefit the patient with lower costs, better benefits, and better coordinated care. On the minus side, patients may have less control over health care treatments, and no control over whether their chosen health care plan continues to be available from year to year. It is a challenge to separate the positive from the negative, because the same factors create both results. A private business can be more innovative and efficient, but if it is not profitable, the private business will leave (or not enter) the

market. The beneficiary who gained the extra benefits for a time, can lose in the long run.

One of the lessons from the initial implementation of Medicare+Choice is that every change to Medicare will have consequences, some predictable, some unanticipated. In fact, the disruption last year, which seemed enormous to those affected, occurred *before* any *new* Medicare+Choice plans were available. Once new types of private plans are offered, other issues are certain to arise. *At this point, two things are clear: first, private market participation in Medicare must be structured to assure beneficiaries have stability in their health insurance coverage; and second, the impact of the BBA is significant and it must be evaluated and understood in order to plan the even greater changes needed to strengthen Medicare for the future.*

Issues Arising from Medicare+Choice Implementation

Beginning late last fall, Medicare beneficiaries began to feel the effects of the program's transformation. Medicare, like other health insurance programs, has always been complex. But, with the advent of new choices, greater private sector involvement, and the accompanying need for information, it has become even more confusing. In order to protect beneficiaries' choices, significant issues, such as payment methodology, risk adjustment and public information and education, will need to be addressed and understood as Medicare+Choice is implemented. We need to address these needs and stabilize the Medicare+Choice program before greater changes take place.

Payment Methodology/Medicare HMO Withdrawals—Last fall, about 400,000 beneficiaries found themselves displaced from their current HMOs when multiple plans terminated their Medicare contracts. The majority of beneficiaries who lost coverage had the option of joining another HMO in their area, but often that meant changing doctors or losing extra benefits that had attracted them to the particular HMO in the first place. Beneficiaries were also entitled to return to original fee-for-service Medicare, but for many that was not a preferred option. Often, these beneficiaries chose managed care because it both relieved them of the financial burden of Medigap insurance payments and offered needed benefits, such as prescription drugs, that are not covered by Medicare. Under the BBA, beneficiaries who lost their HMO coverage and returned to original Medicare were given certain rights to purchase—or repurchase—a Medigap policy, but they would have to bear the significant expense, generally in excess of $100 a month. Even if they can afford Medigap, not all beneficiaries are protected by the rules. Disabled beneficiaries may not have the right to purchase Medigap and no beneficiary is guaranteed the right to purchase a policy with drug coverage.

The Medicare HMO withdrawals at the end of 1998 affected 7 percent of all Medicare beneficiaries in managed care. While only 1 percent lost their managed care option, all of these beneficiaries were deeply troubled, and the general disruption in the HMO market could make other beneficiaries reluctant to join a Medicare HMO in the future.

Several reasons have been put forward to explain the HMO withdrawals from Medicare. The HMO industry contends that the BBA Medicare payment rates and methodology was the chief reason that plans pulled out of certain markets. Whether or not the payments are adequate or fairly calculated is an issue on which AARP does not have enough data to permit us to evaluate the situation. *We believe, however, that it is important for all stakeholders—Congress, the Medicare Commission, HCFA, health plans and beneficiaries—to understand what caused last year's rash of HMO withdrawals in order to determine how to preserve enrollment stability for beneficiaries without undermining the fiscal integrity of the program.*

Most stakeholders agree that it is necessary to change deadlines of the Medicare+Choice program to allow the program to function more smoothly and to attempt to avoid a repeat of last year's HMO withdrawal problem. We understand that one proposal is to move the date for plans to file the Adjusted Community Rate (ACR) from May 1 to July 1. This would allow Medicare+Choice plans to base their next years' benefits and premiums on two quarters of experience. We believe moving the date of the ACR submission to no later than July is a reasonable accommodation to the needs of managed care plans to set their rates based on recent data. AARP continues to believe that plans have the responsibility to identify problems that may affect rates as early as possible. If plans are going to operate responsibly as part of Medicare and deal fairly with beneficiaries, they need to be aggressive in their efforts to set rates appropriately. Changing the timeline for plan submission of ACR data will not be without its impact on beneficiaries, however. It will necessitate adjustments in the information that can be included in the Medicare Handbook, which will have to be carefully worked out in 1999.

Ultimately, the HMO withdrawal situation underscores the importance of original Medicare. Regardless of the market decisions of private health plans, beneficiaries need the security of knowing original Medicare and access to Medigap are there for them.

Risk Adjustment—Health plans have also reported that uncertainty surrounding new risk adjustment methodology contributed to their decisions to pull out of certain markets in 1998, and beneficiaries fear a similar response by health plans this year.

In its 1996 *Annual Report to Congress,* the Physician Payment Review Commission estimated that HMOs received overpayments of about 5 to 6 percent per beneficiary because the populations they enrolled were healthier than the general Medicare population. In recognition of that, the BBA requires HCFA to implement a risk adjustment method to set payment rates based on the "expected relative health status of each enrollee." Risk adjustment is intended to ensure that health plans are neither penalized for enrolling beneficiaries with chronic illnesses nor overcompensated for enrolling healthier beneficiaries. In theory, risk adjustment will make all beneficiaries equally attractive to health plans regardless of their health status. The BBA requires the system to be in place no later than January 1, 2000.

Last September, HCFA released a notice describing the risk adjustment method it intends to implement. The new system will adjust payments to Medicare+Choice plans for each Medicare beneficiary based on whether the individual's "risk factor" is higher or lower than that of an average beneficiary. Specifically, payments to Medicare+Choice plans will be risk adjusted by incorporating diagnosis information into the payment methodology. The information used would be based on inpatient hospital encounter data to determine payments to Medicare+Choice organizations and, eventually, additional encounter data (outpatient hospital, physician services, etc.) will be incorporated into the methodology as well.

We understand that the diagnosis-based or hospital data risk adjuster has several advantages, including that it is more readily available, strongly correlated with future expenses, and verifiable through audit. On the other hand, this approach has met with some criticism. Health plans argue that using hospital-only data to determine diagnosis penalizes plans that avoid hospitalizations, potentially creating inappropriate incentives to needlessly hospitalize Medicare beneficiaries. Also, it does not recognize the cost of treating expensive illnesses that do not result in hospitalizations.

While we understand that available methods of risk adjustment are imperfect, adding risk adjustment is still essential to derive a more accurate payment for Medicare+Choice plans. If plans are to compete fairly in the Medicare market, it will be necessary to minimize risk selection through improved risk adjustment. Prior risk adjusters based on demographic factors are widely recognized to be inadequate to protect the Medicare system. AARP understands that HCFA intends to address plans' concerns about financial impact by phasing-in the implementation of the diagnosis-based risk adjuster. AARP believes that it is important that HCFA move forward with the proposed risk adjuster in order to allow a smooth transition to more accurate payment for plans. Refinement of risk adjustment methodology should continue, as Medicare cannot afford to wait for a perfect risk adjuster before implementing at least a partial solution.

Medicare+Choice Information and Education—In supporting expansion of Medicare choices, AARP emphasized the importance of solid, consumer-friendly information so that beneficiaries can make informed decisions and select the best health plan choices for them. But, we also recognize that educating beneficiaries so that they understand the complex range of choices facing them is an enormous task. Recent research in five cities conducted for AARP by Dr. Judith Hibbard of the University of Oregon found that many beneficiaries were not able to make knowledgeable choices even between the original Medicare fee-for-service program and Medicare HMOs. As more Medicare options become available, this task will grow still more difficult. In addition, for those beneficiaries who do select any of the new Medicare+Choice options, they will need help in navigating within those options. These challenges must be taken very seriously by HCFA, the Congress, health plans, and groups like AARP.

AARP supported Medicare+Choice in order to give beneficiaries the full benefit of innovations in health care delivery. However, Medicare+Choice can realize its potential only if beneficiaries acquire the knowledge that will enable them to exercise their leverage as informed consumers in the marketplace. We support HCFA's efforts to educate beneficiaries and have joined with the Agency as a partner in its education campaign. AARP has also undertaken a campaign to educate our members about the Medicare+Choice program and the new options they may have available to them.

We believe Congress, too, must do its part by providing sufficient resources to enable HCFA to carry out its challenging tasks. This year, for example, we anticipate that HCFA will need to make changes in its beneficiary education campaign to reflect modifications in program timelines, like the ACR filing date, and to respond to problems encountered last year. Medicare has found its $95 million appropriation—less than $3 per beneficiary—barely sufficient to carry out the education campaign. Presently the #800 line is operational only in the five pilot test states and the full Medicare Handbook has been mailed only to those states. By the end of this year, these services must be available nationwide. Therefore, we strongly support the Administration's proposed increase in Medicare+Choice user fees to $150 million. AARP believes this increase is needed to assure that all aspects of the education campaign can be carried out as Congress envisioned, including the #800 telephone assistance line with live operators as opposed to an automated response system.

Greater Medicare Reforms

As we've noted, Medicare+Choice is still in its infancy and many of the changes enacted by the Balanced Budget Act are still phasing in. The overall affect of these changes on beneficiaries, providers and the Medicare program itself is not yet clear and there is much to be learned. The challenges and the successes of Medicare+Choice will have important implications for broader reform of the Medicare program. The amount of "fine-tuning" now under discussion for Medicare+Choice offers ample reason why larger-scale reforms in Medicare must be made slowly and cautiously.

While we have stated the importance of understanding the impact of the changes that have already been made before new changes are layered on top, this does not mean that the status quo in Medicare is acceptable.

Medicare continues to face financial challenges which have to be addressed if the program is to continue to remain strong for current and future beneficiaries. Equally important, Medicare's benefits and delivery system need to be modified to live up to the demands of 21st century medicine. That means that greater reforms are still necessary. The Balanced Budget Act extended Medicare's solvency only until 2008. More must be done to ensure the program's long-term solvency. The program must also be prepared to handle the enormous number of baby boomers who are moving towards retirement.

To this end, AARP believes that there are some fundamental tenets that have guided Medicare and should be the basis of any efforts to reform the program:

- First and foremost, Medicare should continue to be available to all older and disabled Americans despite health status or income. Our nation's commitment to a system in which Americans contribute to the program through payroll taxes during their working years and then are entitled to receive the benefits they have earned is the linchpin of public support for Medicare. Toward that end, AARP views it as unacceptable to create a situation where more Americans would be uninsured by requiring people to wait until they are 67 to receive Medicare.
- Medicare should guarantee a defined set of benefits with payments that keep pace with the cost of the benefit package. Clearly defined benefits, across all plans, provide an anchor on which health plan benefits and the government's contributions are based. On the other hand, a defined contribution, with payments tied to artificial budget targets rather than the cost of a benefit package, creates the potential for both benefits and government payments to diminish over time. The latter would leave beneficiaries more vulnerable to rising health care costs—something over which individual Americans have little control.
- Medicare should keep up with advances in medicine and medical technology in much the same way as do private and employer-provided insurance. This means, among other things, modernizing Medicare's defined benefit package to include prescription drug coverage. Prescription drugs keep people healthy, independent, and out of hospitals. Therefore, there should be a guarantee of drug coverage across all Medicare plans. Without such coverage in every Medicare plan, there would be a greater tendency towards adverse selection of beneficiaries.
- Changes in Medicare financing and benefits should protect all beneficiaries—including those with low-incomes—from burdensome out-of-pocket costs. Medicare beneficiaries should continue to pay their fair share of the cost of coverage, but out-of-pocket costs must be kept affordable. The average beneficiary already spends nearly 20 percent of his/her income out-of-pocket on health care. If cost-sharing is too high, Medicare's protection would not be affordable and many beneficiaries could be left with relatively few coverage options.

- Medicare must have a stable source of financing that keeps pace with enrollment and the costs of the program. Ultimately, any financing source will need to be both broadly based and progressive. Additionally, AARP supports using an appropriate portion of the on-budget surplus to insure Medicare's financial health beyond 2008.
- As private insurance participation in Medicare expands, effective administration of the program will be essential. The agency or organization that oversees Medicare must be accountable to Congress and beneficiaries for assuring access, affordability, adequacy of coverage, quality of care, and choice. This will require things like: ensuring that a level playing field exists across all options; modernizing original Medicare fee-for-service so that it remains a viable option for beneficiaries; improving the quality of care delivered to beneficiaries and ensuring that all health plans meet rigorous standards; and continuing to rigorously attack waste, fraud, and abuse in the program.

AARP is awaiting the Medicare Commission's report. We have reviewed the "premium support" proposal put forth by Senator Breaux. This proposal relies heavily on the private insurance market to provide health insurance coverage to Medicare beneficiaries. As discussed earlier, a step towards greater involvement of private sector health plans in Medicare requires careful assessment and ample time to test the potential impact on beneficiaries. Since many details of this particular proposal are still sketchy it is premature for us to comment on it fully. As more information becomes available, AARP will weigh the proposal—as we will any Medicare reform plan—against the fundamental principles of the Medicare program described above.

In the meantime, AARP will continue to work with the Commerce Committee, and your colleagues in the House and Senate to improve upon the Medicare+Choice program. We also want to work with you to advance a Medicare reform package. The status quo in Medicare is not acceptable. But together we must ensure that any reform package continues Medicare's promise of quality, affordable health care.

Mr. BILIRAKIS. Thank you very much, Ms. Miller. Before I recognize Ms. Archer, the Chair recognizes Mr. Brown.

Mr. BROWN. Ms. Miller, thank you. Congresswoman Lois Capps, who is your Member of Congress, I believe, asked me to welcome you. She could not be here today because of an illness in her family, but wanted to extend her greetings and thank you for traveling all the way across the country.

Ms. MILLER. Well, thank you. Yes, Morro Bay is part of San Luis Obispo County and I am in her district.

Mr. BROWN. And you definitely have a friend in the work she does in this committee.

Ms. MILLER. Thank you.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Ms. Archer.

STATEMENT OF DIANE ARCHER

Ms. ARCHER. Thank you. My name is Diane Archer. I am the Executive Director of Medicare Rights Center, a national not-for-profit organization based in New York. We help seniors and people with disabilities on Medicare through telephone counseling, public education and policy work. I thank the Commerce Committee for this opportunity to testify today.

MRC devotes considerable resources to counseling our clients on how to choose a Medicare health plan. We tell people to choose carefully because quality matters and quality varies. But we can't give callers information to help them choose among the many Medicare plans based on the health care they offer. Good information on health plan quality is not available.

For now we know that many of our clients are forced to choose a health plan based solely on out-of-pocket costs and additional benefits. But a choice that doesn't factor in quality, isn't an in-

formed choice and doesn't make for a competitive market place. To help ensure that seniors and people with disabilities get good care from their plans, they must be encouraged to compete on their health performance.

As a Nation, we should measure the success of the market place and Medicare on how well health plans treat seniors and people with disabilities who need care the most. Currently 75 percent of Medicare costs cover the health care needs of the sickest 10 percent of the Medicare population. The Medicare Program was founded to provide a safety net for these vulnerable seniors and people with disabilities who would otherwise be uninsurable.

If we overlooked the health care needs of these people, Medicare will no longer be the safety net it is intended to be. Risk adjusting payments to health plans are essential if they are to compete for members with costly health care needs. Because of the current payment system, some of the most vulnerable people on Medicare tell us they fear they may not be able to get the care they need from Medicare HMO's.

And we have no evidence about particular health plans to allay their fears. Unfortunately today, Medicare's capitated payment system penalizes plans that develop and promote programs for people with costly health care needs. If they attract too many people with complex conditions, they can't stay in business. As a result, health plans don't compete on the quality of health care they provide to people with costly conditions.

And without good risk adjustment, the Federal Government winds up wasting taxpayer dollars by overpaying HMO's to enroll healthy people. A better risk adjustment system will help the Medicare market place and provide an incentive for plans to enroll people with costly conditions. By the year 2000, plans will be paid slightly more for enrollees who were hospitalized in the previous year to account for higher average projected total cost in the current year.

The new system will begin to compensate those private Medicare plans with higher numbers of members with costly needs. Today choosing a private Medicare plan is not a matter of informed choice, and it can be as risky as a trip to a Vegas slot machine. We will know that the Medicare market place is meeting the health care needs of those who need it the most when private Medicare plans aggressively develop and advertise programs for people with cancer, heart disease and other serious illnesses.

Risk adjustment will push the Medicare market in the right direction, encouraging health plans to compete against each other on the quality of their product, health care, and improved risk adjustments should encourage full disclosure by health plans of their treatment policies and enable people on Medicare to make informed choices about which plan to join now for when they become sick later. With risk adjustment the most vulnerable seniors and people with disabilities on Medicare would not need to fear falling by the Medicare wayside.

Instead, the Medicare Program could become a public/private partnership that we can all be proud of and a legacy for future generations. Thank you.

[The prepared statement of Diane Archer follows.]

PREPARED STATEMENT OF DIANE ARCHER, EXECUTIVE DIRECTOR, MEDICARE RIGHTS CENTER

My name is Diane Archer. I am the Executive Director of the Medicare Rights Center, a national not-for-profit organization based in New York City. MRC helps seniors and people with disabilities on Medicare through telephone counseling, public education, and public policy work. Under a contract with the New York State Office for the Aging, with funding from the Health Care Financing Administration, we operate New York State's Health Insurance Assistance Program hotline. Each year, we field approximately 50,000 hotline calls from people with Medicare questions and problems and provide direct assistance on a variety of Medicare issues to more than 7,000 individual callers. I thank the Commerce Committee for this opportunity to testify on the need to risk adjust payments to private Medicare plans. Only through risk adjustment will these plans have the incentive to develop and promote programs for enrollees with costly conditions and to provide treatment information that consumers need to make informed health care choices.

MRC devotes considerable resources to counseling our clients on how to choose a Medicare health plan. Our counselors tell people to choose carefully because quality matters and quality varies between plans. But, we cannot give callers information to help them choose a private Medicare plan based on the health care they offer. Good information about how private Medicare plans care for enrollees with costly health care conditions is unavailable. For now, we know that many of our clients are forced to choose a health plan based on out-of-pocket costs and additional benefits without factoring in quality. But a choice based solely on costs and benefits is not an informed choice and does not make for a competitive marketplace. To help ensure that seniors and people with disabilities get good care from their health plans, health plans must be encouraged to compete on their health performance.

We as a nation should measure the success of the Medicare marketplace on how well health plans treat those seniors and people with disabilities who need care the most. Currently, 75% of Medicare costs cover the health care needs of the sickest 10% of the Medicare population. The Medicare program was founded to provide a safety net for these vulnerable seniors and people with disabilities who would otherwise be uninsurable. If we overlook the health care needs of the most vulnerable people on Medicare, Medicare will no longer be the safety net it is intended to be.

Risk adjusting payments to health plans is essential if they are to compete for members with costly health care needs. As a result of the current payment system, some of the most vulnerable people on Medicare tell us they fear they may not get the care they need from Medicare HMOs. And we have no evidence about particular plans to allay their fears. Unfortunately, today, Medicare's capitated payment system penalizes plans that develop and promote programs for people with costly health care needs. If they attract too many people with complex conditions, they will go out of business. As a result, health plans do not compete on the quality of health care they provide to enrollees with costly conditions. And without good risk adjustment, the federal government winds up wasting taxpayer dollars by overpaying HMOs to enroll healthy people.

We believe that even the most basic risk adjustment will help the Medicare marketplace and provide an incentive for plans to enroll people with costly conditions. By the year 2000, plans will be paid slightly more for enrollees who were hospitalized in the previous year to account for higher average projected total cost in the current year. This new risk adjustment methodology is an improvement over the existing system because we know that people with costly health conditions like cancer, congestive heart failure, and diabetes are more likely to need extended hospital stays than other enrollees. The new system will no longer reward health plans with a disproportionate number of healthy members. Rather, it will begin to compensate those private Medicare plans with higher numbers of members with costly needs.

Today, choosing a private Medicare plan is not a matter of informed choice, and it can be as risky as a trip to a Vegas slot machine. We will know that the Medicare marketplace is meeting the health care needs of those who need it the most when Medicare HMOs and other private Medicare health plans aggressively develop and advertise programs for people with cancer, heart disease, and other serious illnesses. Because health plans want to attract as healthy a membership as possible, they vie for clients with glossy pictures of seniors riding bikes and swinging on swings with their grandchildren. Risk adjustment would push the Medicare market in the right direction, encouraging health plans to compete against each other on the quality of their product—health care. And, improved risk adjustment should encourage full disclosure by health plans of their treatment policies and enable people on Medicare to make informed choices about which plan to join now for when they become sick later. With risk adjustment, the most vulnerable seniors and people

with disabilities on Medicare would not need to fear falling by the Medicare wayside. Instead, the Medicare program could become a public-private partnership that we can all be proud of, and a legacy for future generations. Thank you.

Mr. BILIRAKIS. Thank you, Ms. Archer. Ms. Wegner.

STATEMENT OF NONA BEAR WEGNER

Ms. WEGNER. I thank the committee for this opportunity for my organization to be represented. The Seniors Coalition in a non-profit, non-partisan advocacy organization representing about 3 million older Americans and their families. This hearing addresses a very important health care issue of deep concern, not only to my members but to every senior citizen.

Over the last decade we have vigorously supported providing Medicare beneficiaries with age-appropriate options so as to place them on an equal footing with the products and services presently available to younger consumers. We were very hopeful, and we still are hopeful, that the Medicare+Choice provisions of the Balanced Budget Amendment will do this.

But as of today, that has not happened. Clearly that was the intent of the passage of the legislation, but the choices which we expected to see available have not come to pass. We believe that there are a number of important factors which have created this problem and I would just like to mention two. First, we are told and on behalf of our members, who inquired about and were told, that the late issuing of HCFA's first interim regulations significantly delayed the entry of products into the market place.

But second, concern over the risk adjuster is a factor which is acknowledged universally as being one of the issues. We acknowledge and truly believe that a risk adjustment factor is critical in balancing affordability and profitability in the development of new health care products. There are both anecdotal evidence as well as the evidence presented today that justifies that. So we will not quarrel with that idea.

But we do want to say that it is important to look at how that risk adjustment is developed and whether or not it reflects accurately the market place balance that must occur for products to be brought on line and consumers to have access to it. It certainly is true that the Medicare+Choice options as envisioned in the BBA would benefit seniors both economically and physically through better health care outcomes.

But for seniors who are economically vulnerable and physically frail, as my co-panelist just said, perhaps more important than choice is quality and availability of access to service. The harsh reality is that there are few products in the market place and seniors have neither choice not cost-savings nor quality right now. I want to digress just a moment, as I was invited to do, to say that we are concerned that in a defined benefit program, that choice does become a problem.

I just want to relate something that happened to me this week. I had a member of my organization who lives in south West Virginia call me and his wife has Parkinson's Disease. Whether it was through the Michael J. Fox discussion of his surgery or not, he and his wife investigated deep brain surgery. Her doctor recommended that treatment for her, but it was not covered by Medicare.

I don't have an answer for him. I know that that is a naughty problem that leads away from this issue, but in looking at what we construct, we have to keep in mind that Medicare was created in an environment in the 1960's in which deep brain surgery was never even envisioned, let along performed. What we see here in all of this are growing pains in which we are trying to restructure the system.

So we really encourage the restructuring of the system. We know that the risk adjuster is a bridge to it. It may not be perfect and I have one more thing I want to say. In which I say, I don't think it is. But we need to do that in order to move it forward. It is like having a child with growing pains. We can't stop raising the child. We can't stop and wait because Medicare must evolve to create a health protection for seniors in the 21st century.

The medical advantages we have today and the way in which the practice of medicine have evolved are far beyond anything that was ever conceived in the original construction of the Medicare Plans. Now let me return back to my other point that I want to make. Is that we are very concerned that basing only, that basing the risk adjuster only on in-patient hospital data has a negative consequence. I will stop there. Thank you.

[The prepared statement of Nona Bear Wegner follows.]

PREPARED STATEMENT OF NONA BEAR WEGNER, SENIOR VICE PRESIDENT, THE SENIORS COALITION

Good morning. I am Nona Wegner, Senior Vice President of The Seniors Coalition, a non-profit, non-partisan senior-citizen advocacy group here today on behalf of our 3 million members and supporters. Thank you for allowing me to speak to you on this critical issue.

The Seniors Coalition has long promoted the concept of providing Medicare beneficiaries with options and alternatives similar to those available to younger health care consumers. We were extremely hopeful that the Medicare+Choice provision of the 1997 Balanced Budget Act would, at last, effect this change.

At this juncture, however, it would appear that neither the hopes of the Congress who passed the measure, nor those of seniors who wanted new choices, have come to pass. Certainly we realize that the late release date of HCFA's interim regulations were one factor that has delayed the entry of products to the market place, but we also believe that industry concern over the risk adjuster is another factor of considerable importance.

We do understand and acknowledge that risk adjustment is necessary to the operation of a competitive marketplace. Alice Rosenblatt, then Chairperson of the Risk Adjustment Work Group of the American Academy of Actuaries, in testimony to the House Ways and Means Committee in 1997 noted: "Risk assessment and risk adjustment are methods intended by policymakers to promote competition the basis of medical and administrative efficiency, rather than risk selection. She goes on to say that the goals of risk adjustment include maintaining consumer choice, protecting the financial soundness of the system and compensating plans fairly for the risks they assume.

Let me stop here and say I am not an actuary, nor am I here to present myself in such a way. I am, however, a consumer, as are Seniors Coalition members, and we are here to voice our concern that the current marketplace is not serving our needs. Of course we want quality and affordability in healthcare services and delivery; these are as important as choice, if not more so. But when there are no products, we have neither choice, nor cost savings, nor quality.

In short, when the regulatory environment is such that companies hesitate to bring products to the marketplace—products that are desperately needed—we must ask why.

The question leads us to the heart of many of our concerns about Medicare and the role of government in our healthcare decision making. Many other experts you have here today will crunch the numbers. I, on the other hand, wish to briefly discuss the impact of this problem in human terms.

The Seniors Coalition has grave concerns about using inpatient hospitalization data as the basis for the risk adjuster for three reasons:

1. It creates an incentive to game the system by hospitalizing seniors who might otherwise be better served with outpatient treatment.
2. Increased hospitalization inevitably adds more cost to an already overburdened Medicare system, worsening an already desperate financial crisis.
3. Reliance on such a model flies in the face of the way in which modern health care delivery has evolved. Inpatient hospital care is no longer the treatment of choice in for the treatment of many types of conditions resulting from acute and/or chronic illnesses. Lack of recognition of this fact can lead to actually diminishing the quality of care given to older Americans.

In conclusion, we believe that four years is too long to wait for HCFA to develop a formula for risk adjustment that takes into account the complexities and standards of practice in medicine today. We are concerned that such a model will not only slow down the entry of new Medicare products to the marketplace but impact negatively upon the financial solvency of Medicare and far more importantly reduce the quality and availability of services to Medicare beneficiaries.

Mr. BILIRAKIS. Well thank you, Ms. Wegner. And of course you heard Dr. Wilensky agree with you and hopefully that, as time goes on, will work itself out. Ms. Miller, when you say that seniors should continue to pay their fair share, is that in relation to the cost of the program or how much a senior can afford? I guess the question goes to, are you advocating means testing the program?

Ms. MILLER. I think that we should have health care for all Medicare beneficiaries regardless of their income, and whether they can pay for it or not.

Mr. BILIRAKIS. Yes.

Ms. MILLER. Our actual goal is Medicare beneficiaries should be able to choose the kind of medical health care option that best meets their needs. And Medicare+Choice is a step toward providing that choice.

Mr. BILIRAKIS. Yes, okay. But you have heard the problems with the cost of the programs. And do you know what I mean by means testing?

Ms. MILLER. Yes.

Mr. BILIRAKIS. All right. I mean right now under the current program you are talking about, let us say, with the Part B premiums, the multi-millionaire pays no more than the poorest person. How do you feel about that?

Ms. MILLER. AARP is not, at this point, I cannot speak for the position on it. We have to look at all issues and respond for the best area of our membership. So I would have to not respond.

Mr. BILIRAKIS. You are being a lawyer on me now, aren't you?

Ms. MILLER. No, I am being honest.

Mr. BILIRAKIS. Do you have a personal opinion? I don't mean on behalf of the AARP. I don't mean to put you on the spot, but you may have a personal opinion.

Ms. MILLER. Absolutely. No, I don't want to give you a personal opinion, if I may take that option. Because there is too much involved here on both sides and it would have to be looked at.

Mr. BILIRAKIS. Ms. Archer, do you have any opinion.

Ms. ARCHER. I do.

Mr. BILIRAKIS. You know, if you can do it quickly.

Ms. ARCHER. Yeah, I am opposed to mean testing. The millionaires do pay a lot more in taxes than the low-income seniors. We want a program that treats everybody equally, that makes everybody, satisfies everybody's needs. Once you start means testing you

begin to create dissention in the program and I believe a lower quality program.

Mr. BILIRAKIS. Ms. Wegner.

Ms. WEGNER. Traditionally my organization has opposed means testing. We would look at an individual proposal, but, and I would not speak about what my organization would do in the future, but traditionally it was opposed.

Mr. BILIRAKIS. Interesting. You have all said that risk adjustment is essential. And yet you have sat through very patiently the rest of the hearing and you have realized the problems that we have with seniors basically being dropped from the program and some of the blame, at least, is being attributed to the new risk adjustment. Do you feel that risk adjustment is so important that it sort of overbalances? Do you know what I mean, Ms. Archer?

In other words, along with risk adjustment we have this problem. And it is a problem that we all consider very serious. How would you respond to that?

Ms. ARCHER. I think I should raise one point that hasn't been raised today. My understanding is there are 9 million people on Medicare today who can't join an HMO even if they wanted to. So that is the beginning of the issue. Risk adjustment, I don't believe, is going to do two things that we need it to do. That you need it to do and consumers need it to do.

From your perspective it is going to save you literally billions of dollars in overpayments to health plans. That is critical to preserving the Medicare Program. I think we all agree with that. And from a consumer point of view, it is the only thing that I see that we can do that will begin to encourage plans to want to try people who are sick. To promote and develop programs for people who are sick.

Mr. BILIRAKIS. So even if we can't solve the immediate problem, you feel that strongly about the risk adjustment process.

Ms. ARCHER. I do.

Mr. BILIRAKIS. Good. Ms. Wegner.

Ms. WEGNER. I would concur. We are concerned that despite the safeguards, which I understand HCFA has tried to implement, that there will be found a way to gain the system. And history has chosen, has told us that that has been the case. We are concerned about the impact on patients about that. But we have to, the fact that we don't have a perfect system, doesn't mean that we shouldn't move toward bettering it.

Mr. BILIRAKIS. And you all agree that choice is significant. So you like the idea of additional choice.

Ms. ARCHER. I would say here that good choice is significant. That in fact what is most significant to seniors is security, stability and affordability. And if you have choice and a market place that is in constant turmoil, that is not good. Choice and health plans that aren't doing right by their members, that is no good. Moreover, I would say seniors don't need a lot of choice and don't want a lot of choice. They want some limited choice to guarantee affordability, security, comprehensive benefits.

Mr. BILIRAKIS. Ms. Archer, on Page 3 of your written statement you say, "today choosing a private Medicare Plan is not a matter of informed choice, but can be as risky as a trip to a Vegas slot ma-

chine." And yet, I am sure you are aware that HCFA has invested a lot of money in this document which is intended to inform seniors and ensuring that they get the information needed in order to make informed choices. Do you have any response to that?

Ms. ARCHER. I would say a few things. No. 1, if anybody has any sort of notion of how they would pick a health plan today, let me know, because I think HCFA would agree that it is just impossible today. Because there are so many factors that we don't understand about each health plan. providers can come and go from one moment to the next. You join, your doctor is in the network, the next thing that doctor is out.

The drugs that they cover can change from one day to the next. You join because your drug is covered, it is no longer covered. The plan terminates and it raises premiums enormously.

Mr. BILIRAKIS. So you don't feel that HCFA, in spite of their effort is adequately——

Ms. ARCHER. Informing people?

Mr. BILIRAKIS. Yes.

Ms. ARCHER. It is not adequately informing people, but it doesn't have the tools to because the data is yet to be available. So I can't fault HCFA for only providing people with information that they have available. The information that we need is just not yet available. We are making some progress with HEDIS data, Health Employer Data Information Set, information and CAHP's data, Consumer Assessment of Health Plans data, which is beginning to measure plan quality.

But again, like risk adjustment, we are only in the beginning stages of that. So it is very hard for people to make an informed choice about their health plan based on quality. On cost it is a little bit easier.

Mr. BILIRAKIS. All right, thank you. I am sure my time has long expired. Mr. Brown.

Mr. BROWN. Mr. Chairman, thank you. Ms. Miller, on prescription drugs there are lots of proposals out there now. Some in the Medicare Commission want to extend coverage of prescription drugs only to Medicare beneficiaries in HMO's. Others want to see universal coverage of all Medicare beneficiaries' prescription drug costs. Others want to see a catastrophic prescription drug plan.

Others want to start from the first dollar and put a limit on annual benefits. AARP, I know, supports some kind of prescription drug coverage. What is your position precisely?

Ms. MILLER. Prescription drugs is good medicine, and I will give you an example with me. Prescription drugs is exactly what is keeping me well. I had a heart attack about 6 years ago, a mild one. But the prescription drugs for high blood pressure has kept me well and I depend on that. Prescription drugs is absolutely good medicine.

Now we don't have enough data yet from the Commission, it is kind of sketchy, so that we can make any decisions along that line. But we need to have prescription drugs as part of the traditional Medicare package.

Mr. BROWN. So you do not support prescription drug coverage only for Managed Care enrollees?

Ms. MILLER. No, it should be across the board.

Mr. BROWN. It should be across the board.

Ms. MILLER. Yes. But I am adding the fact that when things fall out as far as the other plans are concerned and people are without health care, then can then turn to their traditional Medicare and hopefully have prescription drugs along with it. That fills a void.

Mr. BROWN. Okay, thank you. Ms. Archer, one quick question and then a bit longer one. You mentioned that 9 million Medicare beneficiaries cannot join an HMO. That is for geographic reasons, generally?

Ms. ARCHER. Yes.

Mr. BROWN. Okay.

Ms. ARCHER. Yes.

Mr. BROWN. If I understood you correctly, you said there are disincentives in the current system, obvious disincentives, I think, for plans to enroll higher cost people. Could you elaborate on how that works?

Ms. ARCHER. Sure, I mean if a bunch of us got together and said, we want to create the best HMO out there. We want to have the best hospital affiliations, academic affiliations, best providers, we are going to offer the best care for people with cancer. We would go out and actively promote it. People with cancer or heart disease would all join and we wouldn't be paid adequately to service them. We would be out of business very, very quickly. From a market place perspective, the health plans are paid in a way where their incentive is to steer clear from people with costly health care needs in order to do well on the stock exchange.

Mr. BROWN. Okay. My concern is the converse: HMO's marketing only to the healthy. You are saying you are advertising to only get the sickest people. Some HMO's maybe just get a cross-section of people but so often HMO's seem to try to cream skim. Explain that side of the coin to me?

Ms. ARCHER. I don't know if you saw the Kaiser Family Foundation Report, but they did a whole analysis of this issue. But the ads are usually of healthy people exercising, scuba diving and having a lovely time of it and that is all well and good. But again, we think that Medicare's major important role is not to help the healthy people get health care but to help the most vulnerable.

Mr. BROWN. Tell me more. Okay, I understand that philosophically. Tell me more about how they actually market. They run ads with healthy people. Healthy people watch it on tv, they want to join. Less healthy people may not want to join. But give me other examples of how they promote favorable selection?

Ms. ARCHER. No, here is another way. If you call them and you ask what they will do for you if you have cancer or heart disease or some other costly illness. Or if you write them. We have written them and asked them for treatment information. It is all proprietary. So if you are at all concerned about how you are going to be treated, what treatment options are available to you, before you join you are going to find that you can't get a good answer from the plan.

I think there was an article in the Washington Post recently about a man in a Medicare HMO who had AIDS. He had been getting Protease Inhibitor from his Medicare HMO which was closing down. He was trying to find information about other HMO's that

would provide that drug. Which again, was going to keep him going, and he couldn't get it from those HMO's. And for good reason, again. If they were to disclose it, they would be attracting too many people with AIDS and they couldn't afford to do that. So that is a serious problem.

Mr. BROWN. There is certainly an incentive not to disclose it. And there is also an incentive not to offer it.

Ms. ARCHER. That is exactly right. The better ones might offer it, but if it is at all promoted, then they have to, they were going to stop offering it. The ones who just are out there to make money are not going to be promoting or setting up those kinds of programs.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. Ms. Wegner, let me ask you about some concerns that have been raised here today about the phase in of the risk adjuster and the use of in-patient data and the impact of these on the health plans. How would you, would you elaborate actually on the effects of this adjuster would be on beneficiaries and the care provided to him.

Ms. WEGNER. As I pointed out in my testimony, I am not an Actuary, so I can't give you a mathematical model. But as a representative as consumers and judging from history of other kinds of regulatory implementation, there is a distinct, we think, predisposition for this system to be gained. So that hospitalization for perhaps, and I know that the focus has been on a 1-day hospitalization, may not be that, but there will be a focus on hospitalization which is what we are concerned about.

And we have several concerns related to that. One is in-patient hospitalization is the most costly means of treatment. It already impacts negatively Medicare and its financial situation. Two, it is not in the best interest of seniors. And three, it sort of flies in the face of a medical model in which out-patient treatment procedures have become the norm. One of my children had her entire knee replaced and it was done as out-patient surgery.

I was really reluctant. When the second child had it, it was exactly the best way to go. They were happier being at home and it was much better. Now I am not saying my child is the same as a senior, but there are great advantages to not promoting hospitalization. So all of those things make us very concerned when there are other data available to look at treatment. I am sorry that was such a long answer.

Mr. BRYANT. I wanted to ask all three of you three quick questions and I am sort of alone up here, so maybe we can go a little bit over our time. But I will start with Ms. Miller and then Ms. Archer and then Ms. Wegner. In terms of your organizations, No. 1, how many of your members, estimated obviously, would likely join Medicare+Choice as a result of this new risk adjustment?

And second, are you concerned that there may be more of your members in plans now that could conceivably see those plans that they are in now cut services and withdraw as a result of this new methodology? And third and finally, is there any resistance from the more healthy members in these Medicare+Choice Plans now who do not want to see the risk adjuster?

Three sort of detached questions, but if you can recall those, if you can answer those for me quickly. And if you need for me to remind you, I will happily do that.

Ms. MILLER. I don't know the exact percentage, I am taking a guess because we would have to get this from our staff.

Mr. BRYANT. Just your estimate.

Ms. MILLER. Okay, a ball park figure I would imagine it is probably in the 30 percent range that are in HMO's. I don't know how many have, I can't break that down for you. But I will go back to the fact that our beneficiaries have to choose the medical plan that works for them and their best options that satisfies their particular needs. I will give you, again, an example.

I have Medicare and I have a Medigap policy. I don't have prescription drugs. I find that the plan that has the prescription drugs will cost more than if I buy my prescription drugs on my own. So I stay with the plan that I have. However, what about the people that cannot get the Medigap policy and need the prescription drugs. We have to fill that gap. So that is why I say that prescription drugs added on to the traditional Medicare Plan is very, very important so that all people can be benefited by it.

Mr. BRYANT. Mr. Chairman, can I have maybe 2 additional minutes to allow Ms. Archer to answer those questions?

Mr. BILIRAKIS. Sure.

Ms. ARCHER. I don't know how many more are likely to join because of this beginning phase in risk adjustment. Although I think many will join for affordability reasons. I think to the extent that they are concerned about cuts in services and plan terminations, they are already concerned. And I am not sure to what extent. Certainly I haven't read much about risk adjustment in the papers. That is going to be the issue for them.

It is going to be thinking about what they have read about over the last few months about plan terminations. That is going to be what slows down potentially enrollment in HMO's. My understanding is that there has been a tremendous slow down in HMO enrollment over the course of the last 4 months, in part because of these plan terminations. Then I guess your final question was resistance of healthy people to join plans?

I can't see that at all. I think that for healthy people plans can work very well and they are very affordable.

Mr. BRYANT. Thank you. Ms. Wegner, do you have any comments above and beyond that?

Ms. WEGNER. Only that just that my membership has a smaller percentage currently in HMO's, and that may reflect geography and availability or it may reflect a resistance to change. That I don't know, but it is an interesting question that we would like to pursue.

Mr. BRYANT. Thank you all for our testimony.

Mr. BILIRAKIS. Ms. Miller, I just wanted to get clear. You have the fee-for-service Medicare and you have Medigap policy. Your Medigap policy does or does not cover prescription drugs?

Ms. MILLER. Does not.

Mr. BILIRAKIS. It does not.

Ms. MILLER. But there is an option.

Mr. BILIRAKIS. There are some Medigap policies that do?

Ms. MILLER. Right. But in my particular case, when I figured it out with all the deductions and what have you, it was a little less expensive for me to keep the policy I have.

Mr. BILIRAKIS. And still pay for your prescription drugs?

Ms. MILLER. Right.

Mr. BILIRAKIS. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. One of the, in fact, all of the questions I think are good for this panel. One of the questions I wanted to ask is that I am concerned about a lot of the low-income seniors that are beneficiaries, who there is assistance available for Medigap or Medicare supplements but they don't always know about them. In fact the story was that there was a pamphlet sent out that displayed a notice to low-income seniors to be eligible for assistance with premiums and cost-sharings.

And apparently the pamphlet was received and the State program was flooded with calls who need it. Are we doing as good a job as we should on making sure seniors, poor seniors know that this is available?

Ms. ARCHER. The answer is that it is actually been the State's responsibilities and that has been the problem. I think the Federal Government would do a much better job of ensuring that low-income seniors knew about the qualified Medicare Beneficiary Program and other programs to help them with their costs. If Social Security were responsible for handling these applications, my understanding in New York, for example, is that the State local offices, the local Medicaid offices which are required to process the claims, were mistakenly turning down many of our clients because they didn't have Medicaid.

Well, the whole point of these programs is that you don't need to have Medicaid in order to qualify. Other States have incredibly complicated application processes. With the QI2 Program which only gives people $1.07 a month, I have heard from many, many people in the States that it is just too costly to implement it. It costs them more to implement than it does to give people the benefit.

So there are a lot of obstacles for people enrolling in these programs that I think could be alleviated if the Federal Government took the application process on itself and had Social Security do it.

Mr. GREEN. Thank you. Any other comments?

Ms. WEGNER. Mr. Green, I just wanted to add that one of the, I think, one of the barriers to the dissemination of information is that the government always thinks of using dissemination only in government channels. There are many other methods of communication using utility companies, using voluntary organizations, and using other things in the not-for-profit sector and even in the private sector for the dissemination of information.

It has a high probability of reaching low-income seniors, but those channels are not utilized. I would argue that that approach might be cheaper and perhaps as effective as well, and they are often overlooked.

Mr. GREEN. Okay. So we have to do a better job and maybe instead of having 50 State programs doing this, having some kind of standardization for the whole country so seniors will know that these are available.

Ms. MILLER. AARP tries very hard to educate our membership on all issues. We have an 800 number, we have a website and hopefully we can get to all people, not just our own membership, through the website.

Mr. GREEN. Yeah. Although I have to admit I am a member of AARP and I wish I could read the magazine, much less everything else I get in the mail. And I know there is an effort to publicize to the local chapters and I visit. But again, the membership is not, compared to the numbers that we have.

Ms. MILLER. We have forums all across the country. We have our volunteers from AARP to help get that message across.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Green. Anything further, Mr. Brown. You are excused. Thank you so very much for your patience and for your consciousness in wanting to contribute. The last panel consists of Mr. John Bertko, Principal with Reden and Anders, Limited. Heidi Margulis, Vice President of Government Affairs for Humana. Judy Discenza, Chief Actuary of the Blue Cross/Blue Shield of Florida.

Craig Schub, I hope I haven't mispronounced too badly, President of Secure Horizons USA, Santa Anna, California. And Kirk Johnson, Senior Vice President of CNA Health Planners, Chicago, Illinois. Welcome, ladies and gentlemen and again thank you so very much for your patience in sitting out there throughout this very lengthy hearing knowing that you are going to be at the tail end. And ordinarily at the tail end, unfortunately, we never have as many members as we do right at the beginning. But it is certainly not any indication of lack of interest, particularly on a day like this where we have had the last vote unusually early, at 12:30.

So you know many are already on the airplane flying home. But your testimony is very important to us and it is a part of the record and certainly will be a factor in what we might do regarding this problem. I guess we will start off, your testimony, your written testimony, as you know, is a part of the record and hopefully you could just complement it with some oral testimony. Judy Discenza, please kick it off, Ms. Discenza.

STATEMENTS OF JUDITH A. DISCENZA, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF FLORIDA; CRAIG SCHUB, PRESIDENT, SECURE HORIZONS USA; HEIDI MARGULIS, VICE PRESIDENT, GOVERNMENT AFFAIRS, HUMANA, INC.; JOHN BERTKO, PRINCIPAL, REDEN & ANDERS, LTD.; AND KIRK JOHNSON, SENIOR VICE PRESIDENT, CNA HEALTH PARTNERS

Ms. DISCENZA. Mr. Chairman and members of the subcommittee, my name is Judy Discenza, I am Vice President and Actuary of Blue Cross and Blue Shield of Florida. Risk adjustment is a process that varies HMO reimbursements prospectively, as you know, depending on the expected health care needs of its members. This concept is familiar to the insurance industry of course. Actuaries always attempt to match revenues with risk as closely as possible. The method scheduled to be used next year, though, could produce outcomes quite different from what is desired and could ultimately

cause additional plans to exit the market or reduce member benefits.

There are three reasons for this. First and foremost, as you have heard earlier, the current approach to risk adjustment in biased against managed care plans because it is based on in-patient data only. Second, there are unresolved data and systems questions that will accentuate the problems of implementing the method. And third, it could lead to disproportionate reductions in payments to plans.

For this reason, my company urges delaying the current risk adjustment approach so that HCFA and the industry can study, refine and test an improved model. We believe that a refined risk adjuster without the problems of an in-patient only approach, will ultimately help to expand beneficiaries' choices. But implementing a flawed interim solution, will only add to the volatility already affecting Medicare+Choice.

First, why is the approach flawed? The risk adjustment method to be used for the first 4 years is a proxy for true risk assessment. The substitute method uses, as we heard earlier, about 12 percent of admission types to determine the health status of the entire enrolled population. That means that only those seniors who have specific types of hospital stays factor into risk determination.

Those for whom hospital stays are shortened or avoided, are assumed to be in better than average health. Serious, chronic, costly conditions can be totally ignored. Unfortunately also this approach creates incentives for increased and unnecessary hospitalization, exactly the opposite of what managed care tries to do. Perverse incentives happen largely because there is no risk adjustment score for any member treated of a significant health care condition without a hospital admission of at least 2 days.

A risk adjustment method should aid our health care system by encouraging efficient use of health care services. It should not provide incentives for increased hospitalization, tempting plans to shift their limited dollars into much less productive types of treatments. That is the main reason we urge revising the current plan to allow for full study, refinement and testing in a Medicare managed care environment using both in-patient and ambulatory care.

The method, not the concept, is faulty because it is incomplete and because it will be counterproductive. In addition to those flaws though, we face unresolved data and systems issues. Perhaps the most serious of them is the Y2K problem. As you know, Medicare sees Y2K compliance as important enough to suspend a number of initiatives, including some of those mandated by Congress, to free resources to deal with Y2K systems issues.

A similar problem exists for plans in attempting to collect the data needed to implement a risk adjustment system. It takes major systems changes to gather, format and report all of the encounter data that will be needed for risk adjustment. We still have not received the guidance from HCFA regarding the planned October submission of ambulatory encounter data. Plans cannot afford to divert Y2K resources this year.

Finally, at the same time that risk adjustment method creates incentives to hospitalized patients and after 2 years of 2 percent caps on payment increases, HCFA estimates that this proposal will

produce 5 year payment reductions for Medicare+Choice plans of over $11 billion. Even with the proposed phase in, some of the plans that would otherwise be capped at 2 percent, could see their year 2000 payment increase entirely offset.

In Florida, for example, the 2 percent cap on revenues has applied in every county where our program exists. That means that the original 95 percent of AAPCC, I have got maybe one more point if I could continue?

Mr. BILIRAKIS. Please, please proceed.

Ms. DISCENZA. Thank you. Have already been reduced to an average of 89 percent. To continue this process and then overlay risk adjustment, will continue to widen the gap between fee-for-service and Medicare+Choice reimbursement. That will bring the reimbursement down to about 85 percent of AAPCC, not the 95 percent that we have been most familiar with.

And in fact if, when the full risk adjustment, even on the in-patient is implemented, it could drive some areas of our State down to in between 70 and 75 percent. Thank you very much.

[The prepared statement of Judith A. Discenza follows.]

PREPARED STATEMENT OF JUDITH A. DISCENZA, VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF FLORIDA

Mr. Chairman and members of the subcommittee, I am Judith A. Discenza, Vice President and Actuary for Blue Cross and Blue Shield of Florida. Our Health Options plan is a large Medicare risk contractor with an enrollment of approximately 123,000 Medicare beneficiaries.

I appreciate the opportunity to testify before the Subcommittee today on how HCFA's current approach to implementing risk adjustment will heighten already existing threats to the Medicare+Choice (M+C) program. As a result of constrained payments and the business risks of implementing the regulations, more than 500,000 Medicare beneficiaries were affected when health plans in 1998 scaled back their service or decided not to participate. The result is that Medicare beneficiaries were left with fewer, not more, health plan choices. Because of uncertainty related to regulation and reimbursement around Medicare+Choice and in large part, uncertainty around the risk adjustment methodology, continued volatility in Medicare+Choice is likely.

In light of the existing serious issues surrounding Medicare+Choice, we urge delaying the current risk adjustment approach and encourage HCFA to work with the industry to study, refine, and test a risk adjustment model. While we support efforts to devise and apply more effective methods of risk adjustment, we are concerned that HCFA's current approach will ultimately cause health plans to exit the program or significantly reduce benefits for three reasons:

- First, HCFA's current approach is flawed because it only uses inpatient data;
- Second, HCFA's current approach is fraught with unresolved data and systems questions, all of which will accentuate the problems of implementing an inherently biased risk adjustment methodology; and
- Third, even in the first year of the phase-in, HCFA's current approach could lead to significant proportionate reductions in payments to plans, particularly in areas that have been capped at 2 percent for several years running.

I shall now address these points in more detail.

I. THE CURRENT RISK ADJUSTMENT METHOD IS FLAWED BECAUSE IT RELIES ON INPATIENT DATA

Currently, HCFA is proposing that a proxy be used for true risk assessment. The substitute methodology is based only on inpatient hospital data.

Using only inpatient stays of two days or more will also create an incomplete picture of a plan's health risks. For example, any attempt to identify diabetics by using hospitalization data will almost certainly miss most of them. One would need data on physician visits, or better yet, pharmacy data, to identify beneficiaries with diabetes.

Relying on hospital stays of two or more days means that only those seniors who have specific types of hospital stays provide the sole means of determining health status for the entire enrolled population. Those for whom hospital stays are shortened or avoided are assumed to be in better than average health.

The proxy being implemented also creates a situation in which inpatient stays could increase, driving up medical costs. The method presents problems because a key objective of managed care is to focus on prevention and thereby minimize the frequency of hospitalization. A hospital-based risk adjuster provides incentives for increased and unnecessary hospitalization and provides disincentives for plans that successfully minimize the need for hospitalization.

A primary goal of the health care system is to provide appropriate care at the appropriate time to individuals. Much of the health services and clinical research of the past 10 years has focused on excess capacity in the health care system and the resulting overuse of health care services. Blue Cross and Blue Shield of Florida is concerned with overuse of services. An appropriate risk adjustment methodology, by providing appropriate reimbursement and incentives, will aid our health care system by encouraging efficient use of health care services. However, risk adjustment, which provides incentives for increased hospitalization, will have the opposite effect.

The penalty results from the absence of a risk adjustment "score" for any member treated for a serious condition without a hospital admission of two or more days. For example, a member who undergoes an angioplasty in an outpatient clinic will not receive a "score" for having a serious condition, even though his or her care was as effective as a fee-for-service (FFS) beneficiary treated as an inpatient. The only way that a health plan gets "credit" for enrolling a high-risk beneficiary is if the beneficiary is admitted to a hospital.

Further heightening the incentive against appropriate care is the exclusion of short-stay admissions from risk adjustment scoring. Excluding one-day stays from the payment model is questionable. As an example, an individual with a particular diagnosis who is enrolled in Medicare FFS may be hospitalized for three days. An individual with the same diagnosis enrolled in a M+C plan may be hospitalized for only one day, then moved to a sub-acute facility (for which no "score" is credited). When short stay admissions are eliminated from the risk adjustment process, M+C plans may be penalized in that they receive no additional payment for treating these patients because the patients did not have a qualifying inpatient admission.

An additional problem is the exclusion of low frequency, but potentially high-cost, admissions due to sample size limitations. The interim risk adjustment method does not include diagnoses that occur among fewer than 1,000 Medicare beneficiaries—even if these conditions are associated with extraordinary medical costs. Thus, a plan that enrolls a beneficiary with one of these rare, high-risk conditions would not receive credit for needed care.

Over the years managed care has capitalized on new technologies and advancements in medical treatments to keep people out of the hospital. Hospital stays have decreased substantially over this period. Rather than move the trend in the opposite direction, we urge revising the current risk adjustment plan to allow for full study, refinement, and testing in a Medicare managed care environment.

There are two lessons which we can learn from the current examples of systems which use risk adjustment: 1) because they do not cover individuals over 65, they do not provide complete models for the Medicare+Choice population; and 2) they all either use or recognize the need to move to a full encounter model. In Washington State, the covered population includes public employees and non-Medicare retirees, and uses a risk adjustment model that is based on both inpatient hospital and ambulatory data. In Minneapolis, the covered population includes those who are less than 65 and also uses a risk adjustment model that is based on both inpatient hospital and ambulatory data. In California, the covered population includes those less than 65 and utilizes an inpatient only risk adjustment model, but recognizes the need to move to a full encounter model as data becomes available.

II. THE CURRENT RISK ADJUSTMENT APPROACH CONTAINS UNRESOLVED IMPLEMENTATION PROBLEMS

Compounding the conceptual problems of HCFA's current risk adjustment method are unresolved implementation problems that stem largely from two issues:

(1) The limited ability that health plans have to validate the risk adjustment calculations or replicate the model; and

(2) Data and systems complications, particularly surrounding year 2000 compliance.

Limited Validation/Replication ability

A major factor in an organization's decision to offer a Medicare+Choice plan is the ability of the organization to forecast revenues. Health plans face significant uncertainties because it is difficult to validate or replicate HCFA's risk adjustment calculations. Additionally, because HCFA has not yet disclosed the formulas used for components of the risk adjustment process it is impossible to replicate the analyses.

Data and Systems Complications—The most important systems issues revolve around the Year 2000 (Y2K) problem. Plans are currently making a major effort to ensure that "Y2K" does not disrupt services for their Medicare and non-Medicare enrollees. Medicare sees Year 2000 compliance as so important that it has suspended a number of initiatives—including initiatives mandated by Congress—to free resources to deal with Y2K systems issues. At least 15 HCFA initiatives have been delayed or modified due to Y2K concerns:

- The implementation of SNF consolidated billing.
- The implementation of new payment systems for ambulatory surgical centers and hospital outpatient services.
- The implementation of new payment methods for home health agencies.

The purpose of these actions is to minimize the number of system changes that might interfere with the ability of contractors to make sure that information systems are ready for the Year 2000 and are able to process claims without interruption. A similar problem exists for the data needed to implement a risk adjustment system. We have not received guidance from HCFA regarding the planned October submission of ambulatory encounter data. It is vital to have information such as the required fields, implementation instructions, and data format requirements with sufficient time for system changes well before the data is required to be submitted. The burden of system changes around these new requirements comes at a particularly bad time in relation to system changes for Y2K

A related issue is what will happen in the event of a computer systems failure. There is a possibility of computer systems failure anywhere in the process—i.e., in the transfer of data, in the processing of data, etc. Computer failures related to the Year 2000, particularly for hospitals that must transfer data to plans or directly to fiscal intermediaries are special concerns. As the HCFA Administrator noted in recent testimony before the House Ways and Means Subcommittee on Health:

> "Health care providers must be Year 2000 compliant in order to bill us properly and continue to provide high quality care and service to Medicare beneficiaries . . . Our monitoring indicates that some . . . providers could well fail. We are providing assistance to the extent that we are able, but that likely will not be enough. This matter is of urgent concern, and literally grows in importance with each passing day."

The current risk adjustment method contains unresolved data and information systems issues. For example, it is unclear how plans will be able to check for completeness of data *arriving* at HCFA for risk adjustment. Plans will face challenges in checking for data completeness—they may have trouble with fiscal intermediaries or with the editing process. In addition, plans may have difficulty getting data on all services, particularly from capitated providers. The detail of the data or the process at this time is insufficient to provide confidence that all data are being transmitted, received and used appropriately.

III. SIGNIFICANT REDUCTIONS IN PAYMENTS TO PLANS

HCFA estimates that this risk adjustment proposal will produce five-year payment reductions for Medicare+Choice plans of $11.2 billion. Such reductions are likely to reduce the health plan choices available to beneficiaries and the benefits that these plans can offer.

Even with HCFA's proposed phase-in—in which only 10 percent of the risk adjustment effect kicks in—some of the plans that are again capped at 2 percent could see their year 2000 payment increase entirely offset. In 1998 and 1999, virtually all Medicare beneficiaries lived in areas that receive 2 percent payment increases; we expect that millions of Medicare beneficiaries will again see plans in their areas receive 2 percent in 2000. HCFA estimates that this risk adjustment method could trim as much as 2 percent from some plans" payments. In addition, all Medicare+Choice plans are required to pay a user fee to defray the costs of HCFA's informational campaign, which will probably be about 0.4 percent. Thus, despite acceleration in private sector health care costs in 2000, some M+C plans might actually see a decrease if HCFA implements this risk adjustment method in 2000.

IV. CONCLUSION

Congress created the Medicare+Choice program in the Balanced Budget Act of 1997 (BBA) to expand the types and number of private health plans offered to Medicare beneficiaries. However, as a result of constrained payments and the business risks of the implementing regulations, health plan options and choices have not expanded significantly; in fact, they have contracted in many areas. The premature adoption of a risk adjustment method will only intensify the volatility of the Medicare+Choice program.

Blue Cross and Blue Shield of Florida believes that a refined risk adjuster—without the inherent bias of the inpatient-only approach—can further the objective of expanding the choices available to Medicare beneficiaries. However, prematurely implementing interim solutions could well work against this objective.

As stated in the beginning of this testimony, we urge delaying the current risk adjustment approach to give more time to study, refine, and test a valid risk adjustment model in a Medicare managed care environment. We look forward to a continued dialogue with HCFA to ensure a proper approach to risk adjustment and, hence, the viability of the Medicare+Choice program.

Thank you for the opportunity to speak with you on this important issue.

Mr. BILIRAKIS. Mr. Schub, is that correct? Naturally, I am going to get it wrong.

Please proceed.

STATEMENT OF CRAIG SCHUB

Mr. SCHUB. Thank you, Mr. Chairman and members of the subcommittee. Thank you for this opportunity to comment on the issues related to the implementation of the Medicare+Choice risk adjuster provisions of the Balanced Budget Act. I am Craig Schub, President of Secure Horizons USA. That is PacifiCare's health plan for seniors. PacifiCare provides health coverage for 3.5 million individuals in 10 States.

Through Secure Horizons we serve nearly 1 million Medicare beneficiaries, the largest Medicare enrollment nationwide. The preceding Panelists and those to come will detail the technical and methodological problems that plague the risk adjusters and threaten the goals of the Medicare Risk Program, but I would like to focus my remarks on the cumulative impact of these problems on providers and beneficiaries.

Given our experience in 1998 and 1999, where we saw an exodus from the Medicare+Choice Program, PacifiCare is very concerned that providers leaving networks and health plans, exiting from Medicare+Choice, could continue and become particularly acute in mid 2000 without corrective action. This will leave beneficiaries with fewer choices for coverage and greater out-of-pocket cost. Our Medicare Provider Networks have become fragile in some areas as payment is stretched thinner and thinner.

We have also experienced difficulty attracting new providers to our Medicare Networks. The reason, the lower payment differential between Medicare+Choice and our prime competitor, which is the fee-for-service system. It is increasing. The proposed risk adjuster further widens the differential by adjusting payments, often already discounted payment schedule that is currently less than 95 percent.

And I understand that is different as has been previously stated today. HCFA asserts that the proposed risk adjuster merely affects health plans, not the providers and beneficiaries. It ignores the latest and predominant provider models and contracting methods. Namely, the health plans contract with local provider groups on a

percentage of premium capitation basis. Over the preceding years, this model had expanded the provider choices for beneficiaries.

It has given physicians autonomy in treating their patients within a competitive and accountable delivery system. PacifiCare contracts with over 350 medical groups that represent over 66,000 physicians and hospitals. And we pay them a contractually defined percentage of the per member premium. PacifiCare estimates that in the first year of implementation, risk adjusters will reduce the cost to the company of up to $64 million. But that money otherwise would have gone directly to providers, paid for health prevention programs, such as those that identify, that provide mammography screening for early identification of breast cancer, diabetes management and other quality management programs.

Even more problematic is the fact that reduced provider payment will be the direct result of not having hospitalized more of their patients in lieu of more cost-effective alternatives. The end result is that providers as well the plan are paid less than is warranted by the benefits and the actual severity of the illness that the plan carries.

This clearly affects the willingness of providers to participate in Medicare+Choice Plans. But most importantly, it is the beneficiary who is going to experience reductions. Where no providers will contract at the premium rate paid by Medicare+Choice, no choice exists. And for seniors who are enrolled in a plan that is no longer available, benefits they once received at no cost must now be paid for through expensive Medigap Plans or out of their own pockets.

Seniors that can and do remain in a Medicare+Choice may see their benefits reduced or co-payments increased. The beneficiary impact is especially troublesome when one considers that a larger percentage of lower and middle income beneficiaries enroll in Medicare+Choice Plans. Additionally, the nature of patients' specific risk adjustment raises the questions of privacy that I do not believe have been seriously explored.

Today seniors are satisfied getting more benefits and better care from HMO's as demonstrated in even recent HCFA studies. That is why, in an effort to not further jeopardize the choices envisioned by the BBA, PacifiCare proposes a delay in the implementation of the risk adjusters until we can achieve the following three objectives. One, a fair and sound methodology is developed. Two, adequate HCFA information systems are in place. And three, a stable and predictable and timely process is established for determining risk adjuster payment rates. Thank you.

[The prepared statement of Craig Schub follows.]

PREPARED STATEMENT OF CRAIG SCHUB, PRESIDENT, SECURE HORIZONS USA, ON BEHALF OF PACIFICARE HEALTH SYSTEMS

I. INTRODUCTION

Mr. Chairman and members of the Subcommittee, thank you for this opportunity to comment on issues related to the implementation of the Medicare+Choice risk adjuster provisions of the Balanced Budget Act of 1997 (BBA). I am Craig Schub, President of Secure Horizons USA, PacifiCare Health Systems' Medicare plan. PacifiCare is based in Santa Ana, California and provides health coverage for more than 3.5 million individuals in ten states—Arizona, California, Colorado, Kentucky, Nevada, Ohio, Oklahoma, Oregon, Texas, and Washington—and the territory of

Guam. Through Secure Horizons, we enroll nearly one million Medicare beneficiaries—the largest Medicare enrollment nationwide.

With the passage of the BBA, Congress created the new Medicare+Choice program to spur competition, expand health care choices for seniors, and extend the solvency of the Medicare Trust Fund. PacifiCare was, and continues to be, pleased to have a significant role in supporting these goals. However, Congress' intent simply will not be realized if the Medicare+Choice program is permitted to stay on its current course. Unless Congress takes corrective action, the number of providers who refuse to contract with Medicare+Choice plans will increase, and health plan withdrawals will continue at a more rapid pace. Beneficiaries will be left with fewer choices for health coverage, disruptions due to changes in the availability of providers, greater out-of-pocket costs, and higher Medigap premiums for those who are forced to return to the traditional Medicare fee-for-service program.

The risk adjuster, as proposed by HCFA, is one of the most troubling factors that threaten the stability of the Medicare+Choice program. It poses two fundamental problems: 1) it exacerbates the cumulative impact of payment reductions to Medicare+Choice plans; and 2) it creates unworkable and burdensome administrative processes that increase plan costs and raise the likelihood of inaccurate payment. Taken together, these problems will widen the growing disparity between payment to Medicare+Choice plans and reimbursement under fee-for-service. This will make it difficult for Medicare+Choice plans to operate in certain markets and to maintain the level of benefits and services to which beneficiaries have become accustomed. It is unrealistic for HCFA or Congress to assume that a disparity of this magnitude will have no adverse impact on providers, delivery of services, or health care options for seniors.

II. THE PAYMENT BACKDROP

The BBA established a new payment formula for Medicare+Choice plans. Plans receive the highest of a minimum payment floor, a phased-in blend of national and local rates, or an annual minimum two percent payment update. The BBA also limited the annual rate of growth in Medicare+Choice to Medicare fee-for-service growth minus 0.8 percent in 1998 and fee-for-service growth minus 0.5 percent from 1999 to 2002. These provisions were estimated to achieve $22.5 billion in budgetary savings over five years.

In fiscal years 1998 and 1999, HCFA assessed a $95 million user fee on Medicare+Choice plans to fund the education campaign for 100 percent of the Medicare beneficiaries, even though only approximately 15 percent of the Medicare population are in Medicare+Choice plans. Depending upon the year, this user fee reduced the minimum update by 18%-25% for many plans. This is essentially an additional tax imposed on the plans. HCFA is asking for authority to assess a fee of $150 million in FY2000, despite the fact that the BBA only authorizes a $100 million user fee for 2000.

It is against this backdrop of significant payment reductions that the risk adjuster is imposed. According to HCFA's own calculations, the risk adjuster, which will be phased in beginning in January 2000, will reduce payments to Medicare+Choice plans by an additional $11.2 billion (or 7.6%).

III. KEY METHODOLOGICAL FLAWS OF THE RISK ADJUSTER

A. Ignores Budget Neutrality

By providing for implementation of a risk adjuster in BBA, Congress intended to improve payment accuracy by paying plans less to take care of healthier individuals and more to care for sicker individuals. The BBA included a budget neutrality requirement that applies to Medicare+Choice payment provisions, including the risk adjuster. HCFA, however, refuses to implement the risk adjuster in a budget-neutral manner. Its methodology is designed to extract additional savings ($11.2 billion) from Medicare+Choice plans in contravention of the budget agreement.

B. Improperly Relies on Inpatient Data Only

HCFA's initial risk adjuster model attempts to correlate health status with individual patient diagnoses based only on inpatient admissions. This ignores the fact that advances in medicine provide for treatment of many serious diseases in outpatient settings. For example, the care for a cancer patient has changed dramatically from inpatient-based to outpatient-based with better results. Many cancer patients require few, if any, hospitalizations, but they do require costly medications and services. Yet, under the proposed risk adjuster, they would be counted as "healthy" patients, and their plans and providers would not receive an appropriate adjustment to cover their expensive treatments.

Moreover, the HCFA model establishes a financial incentive to hospitalize beneficiaries. Although this is unlikely to affect the manner in which the vast majority of health plans deliver care, it does create a perverse incentive that is not in the best interests of the beneficiary or the ultimate payor—the federal government.

We do not believe it was Congress' intent to penalize health plans for providing patients with the services most appropriate for their conditions. Nor is it good public policy to incentivize costly and inappropriate hospitalizations. In order for a risk adjuster model to differentiate between good medical management and health status, it must include diagnoses of beneficiaries in the outpatient and ambulatory settings, as well as the inpatient setting.

C. Excludes One-Day Hospital Stays

The HCFA model improperly excludes encounter data from one-day hospital stays. As with the reliance on inpatient data, exclusion of one-day hospitalizations creates perverse incentives. It encourages providers to lengthen hospitalizations to two days which would not be desirable from a quality or efficiency perspective.

D. Ignores Investments in Initiatives to Improve Member Health

Health plans typically engage in numerous efforts designed to improve the health of its members, such as preventive services, disease management, wellness programs, chronic care initiatives, and quality measurement and reporting. To the extent that these programs are successful in improving health outcomes (e.g., preventing a heart attack), the health plan will receive lower payments from HCFA. Again, the methodology results in a bias against health plans. The costs associated with these quality-of-care programs are real, but because they are invisible, plan revenue ultimately will decrease. Consequently, plans will be less able to continue to build upon these innovations in health care management and delivery.

E. Excludes an Institutional Adjustment

By excluding an institutional adjustment from the risk adjuster methodology, HCFA will be overpaying for institutionalized beneficiaries and underpaying for all others. Since health plans tend to enroll fewer institutionalized members, the result is a negative bias in Medicare+Choice payments.

F. Misstates Cost in the Year of Death

Providers who incur significant costs in caring for a beneficiary in the last year of life will not get paid for these costs under HCFA's proposed methodology. This is because the payment will not be determined until eighteen months after the death in many cases. Unless a beneficiary is still in the program at the time of payment, the payment will not be directed to the plan in which he or she was enrolled.

IV. KEY SYSTEMS ISSUES

A. HCFA's Information Systems are Insufficient and in Some Cases, Inoperable

HCFA's information systems are unable to accept, process, or manipulate correctly much of the data that health plans already have submitted. For example, a system change implemented in October 1998 has prevented HCFA from tracking beneficiaries who have moved from plan to plan, thus understating inpatient costs for those members. The problem is so acute that despite its statutory duty to provide plans with payment estimates for January 1, 2000, by March 1st of this year, HCFA has informed plans that they should rely on their own estimates for purposes of developing their benefit packages. It is our understanding from HCFA that hospitalizations of up to one-third of PacifiCare's members in California (added as a result of a recent merger) may not be included in its risk adjustment payment calculation due to problems with HCFA's information systems and processing of plan encounter data.

HCFA is struggling to meet the challenges of Year 2000 compliance, and this is adversely affecting its ability to properly implement the risk adjuster. The situation is not likely to improve in the near future. This raises serious questions about the integrity of the data upon which HCFA relies and the accuracy of the resulting payment adjustments. Prior to using a data set for the development of payment rates, HCFA has an obligation to assure itself and those who will be paid under the system that the data is of the highest integrity. Tests should be performed to challenge the validity of the data in each of the key variables used in the payment process. The data also should be reconciled to other sources within HCFA to assure that it is complete and accurate. Moreover, HCFA has a fiduciary as well as administrative responsibility to advise Congress on systems that do or do not work when advancing from theory to operations, particularly when something as fundamental as payment

for Medicare services is at stake. It is unclear whether HCFA has undertaken these critical verification and disclosure functions.

B. HCFA's Data Requirements Impose Excessive Burdens and Costs on Plans

The HCFA risk adjuster data requirements are extraordinary, forcing plans to divert resources away from health care services for members in order to pay for expensive information systems and operations. To date, plans have not been provided sufficiently detailed information to reconcile data records or ensure accuracy. As a result, plans cannot determine whether or not HCFA will pay appropriately.

V. IMPACT ON PROVIDERS AND BENEFICIARIES

HCFA's assumption that the proposed risk adjuster merely affects health plans ignores the reality of the latest provider models and contracting methods—namely, contracting with local provider groups on a "percent of premium capitation" basis. Formative work on appropriate plan payment levels and diagnostic cost groups were based on less sophisticated delivery models as opposed to those that are commonly in place today in mature managed care markets. While more traditional provider models survive, the most rapid and stable growth in managed care has been built on contracting with local providers.

If inpatient diagnoses under-represent the true illness burden of many managed care seniors, then the providers who care for them necessarily feel the impact of the proposed risk adjuster. PacifiCare contracts with over 350 medical groups and hospitals and pays them a contractually defined percentage of the per-beneficiary premium. PacifiCare estimates that in the first year of implementation, risk adjuster reductions will cost the company up to $64 million. Approximately $54 million of this amount will be borne by its providers. The end result is that the providers, as well as the plan, are paid less than is warranted by the actual severity of the illness burden of the plan's members. This clearly affects the willingness of providers to participate in Medicare+Choice plans.

Reduced Medicare+Choice payments already have adversely affected PacifiCare's ability to renegotiate provider contracts; implementation of the proposed risk adjuster will exacerbate the situation. For example, in late 1998, many providers concluded that Medicare+Choice payments for 1999 were inadequate to support the continued delivery of quality health care services. They opted to return to traditional Medicare because fee-for-service payment was more lucrative. In total, PacifiCare exited 25 counties in five states, affecting 17,632 beneficiaries. And we were not alone. For 1999, nearly 100 plans withdrew from some of their Medicare+Choice markets, affecting 500,000 beneficiaries.

By encouraging the migration of expensive patients back to fee-for-service Medicare, the risk adjuster defeats Congress' stated purpose of ensuring more choice, competition, and savings through the efficiencies and quality management of Medicare+Choice plans. Seniors also experience a financial burden. Benefits they once received at no cost must now be paid for through expensive Medigap plans or out of their own pockets. Seniors that do remain in a Medicare+Choice plan may see their benefits reduced and/or their co-payments increased. The beneficiary impact is especially troublesome when one considers that larger percentages of lower and middle income beneficiaries enroll in Medicare+Choice plans. Predictable and accurate payments are essential to patient protection, provider financial stability, and the ability of health plans to serve more markets.

VI. CONCLUSION

There are numerous other BBA implementation problems that impact reimbursement and Medicare+Choice plan operations. We have attached as an exhibit to this testimony a brief description of some of these issues. The risk adjuster must be considered in the context of all of the implementation problems because their cumulative effect seriously threatens the viability of the Medicare+Choice program.

In addition to the specific recommendations mentioned above, PacifiCare proposes a further delay in implementation of the risk adjuster until the following conditions are met:

1) A fair methodology is developed;
2) Adequate HCFA information systems are in place to ensure complete and accurate data; and
3) A stable, predictable, and timely process is established for determining risk-adjusted payment rates in a budget-neutral manner.

PacifiCare appreciates this opportunity to present this testimony to the Subcommittee. We look forward to continuing to work with Congress and HCFA to ensure the successful implementation of the Medicare+Choice program.

Mr. BILIRAKIS. Thank you, sir.
Ms. Margulis.

STATEMENT OF HEIDI MARGULIS

Ms. MARGULIS. Thank you, Mr. Chairman. In 1997, Congressional leaders had a vision. To deliver more health care benefits to Medicare beneficiaries at lower cost by providing them with the same kinds of private health care choices you and I have. Mr. Chairman, members of the committee, I am Heidi Margulis, I represent Humana, a company who covers 500,000 Medicare+Choice beneficiaries.

Beneficiaries for whom we are privileged and proud to be providing more benefits, including prescription drug coverage, preventive services and disease management programs that are demonstrably improving the health and well-being of those seniors.

We support your vision and the goals of the BBA and are here to discuss how the proposed risk adjustment payment methodology affects Medicare beneficiaries blurs the vision you had in 1997.

Let me state for the record, Humana supports risk adjustment done correctly. I have three key messages today about the risk adjustment methodology. First, HCFA should adopt a risk adjustment methodology that reflects the perspective health care needs of patients. Second, HCFA's current risk adjustment proposal is based on insufficient data that will cause seniors harm and should be reevaluated prior to implementation.

And last, Congress and HCFA should delay this risk adjustment proposal and set a course to implementing one with adequate and supportable data. The new risk adjustment proposal which reduces payments to plans by billions more than you intended will have significant consequences on the availability of M+C Plans for seniors. This proposed payment reduction comes on the heels of three other significant payment reductions, both intended and unintended; an 8-percent reduction relative to fee-for-service, payment reductions due to the removal of graduate medical education, and the payment of user fees for beneficiary information materials.

Risk adjustment methods can be implemented either to save money or in a budget neutral manner. The method HCFA plans to use does indeed save money for Medicare, but it does so by taking the money out of the pockets of beneficiaries by unnecessarily reducing payments and undermining seniors access to choice.

The combination of risk adjustment and these payment reductions together may lead to more health plans withdrawing from the program leaving some seniors with fewer or in some cases, no Medicare HMO choices. I don't believe that was your intent and I urge you to evaluate the current proposal for risk adjustment. There are reliable and accurate ways to develop risk adjusters that correctly reflect the future health care costs of beneficiaries. Humana previously worked with the State of California in developing risk adjusters for the health insurance plan of California, the HIPC.

Experience taught us that cooperation, communication and a simulation for any major payment change, worked for both government and beneficiaries. We have been involved in risk adjustment work group discussions with HCFA for some time and have shared

perspectives on the effect of various risk adjustment models and how the private sector risk adjusts. We believe that together we can develop a workable risk adjustment methodology to ensure that payments to plans are accurate and truly reflect the future health care costs of our members.

We need time and HCFA's continued cooperation and understanding of what will and will not practically work in the market place and ask for your assistance in that. In my written testimony and others, you have heard about the complications caused by HCFA's proposed methodology. Let me highlight just one. Current model relies exclusively on in-patient hospital data. No data on services provided outside the hospital or in other institutional settings are used.

Therefore it rewards hospitalizing patients, a trend that has dramatically changed over the past several years. Private health plans work to keep people out of the hospital by stressing prevention and the best practices of disease management. As a Humana example, we are recognized nationally as a leader in disease management programs from diabetes to complex chronic conditions to chronic heart failure.

As part of these programs members collaborate with their caregiver to coordinate care, hopefully avoiding hospitalizations. Patients like these programs and health outcomes are measurably improved. These trends should be the mainstay for the Medicare+Choice Program as well. The methodology proposed by HCFA penalizes plans that have these disease management programs because there will be fewer hospitalizations.

Disease management programs aren't free, we bear the cost of these innovative treatment programs. Based on our experienced in our congestive heart failure program, we expect to reduce an estimated 2,300 hospital admissions for our 4,000 beneficiaries enrolled in this program. Under the new methodology, we will lose $12,000 per admission, a $28 million loss which could translate into—may I, I am close to the end.

Mr. BILIRAKIS. Please continue.

Ms. MARGULIS. [continuing] In prescription drug coverage for all seniors in a market. Congress and HCFA should take additional time to determine a risk adjustment method. I urge you to delay the implementation of this proposed risk adjustment methodology for at least 1 year and stop the phase in of a flawed system. Become an active participant in helping us get this done correctly for the 6 million seniors who have made this choice and for those who wish to make this choice. Thank you.

[The prepared statement of Heidi Margulis follows.]

PREPARED STATEMENT OF HEIDI MARGULIS, VICE PRESIDENT OF GOVERNMENT AFFAIRS, HUMANA, INC.

Introduction

Good morning, Mr. Chairman. I am Heidi Margulis, Vice President of Government Affairs at Humana, Inc. I am pleased to be here this morning to talk with you about the effects of risk adjustment on Medicare+Choice organizations. Humana has been an active participant in the Medicare program since the mid 1980's—we currently provide coverage for over 500,000 Medicare+Choice enrollees and are committed to continued participation in this program. We have also been active in the discussions that have occurred between managed care plans and HCFA on the topic of risk adjustment.

One of HCFA's goals in implementing a risk adjustment system[1,2] for Medicare+Choice is to ensure that Medicare payments to health plans are accurate and that they reflect the health care needs of enrolled members. We believe that this is a laudable goal and are committed to working with HCFA and other interested parties in this endeavor. Payments that are risk adjusted based on health care diagnostic data appear to be, on the surface, an improvement over the current methodology, but only *if designed fairly and implemented correctly.* My testimony addresses the issues that Humana has identified and the potential effects of risk adjustment on Humana's 500,000 enrollees, and the Medicare+Choice program.

Risk Assessment and Risk Adjustment

It may be helpful to first describe the difference between risk assessment and risk adjustment. *Risk assessment* is a means of determining objectively how much an individual or a subgroup differs in cost from the average of the entire group. Individuals who are projected to incur more costs for medical services are considered relatively high risks (and, thus, have higher risk scores) than those who are expected to incur lower costs.[3] Risk assessment can be accomplished using only demographic data, with diagnostic information, or through use of health status surveys.

Risk adjustment may be called "health-based payment." It is a process that can be used to determine the amount of funds that should be allocated to account for the differences in risk characteristics. While all covered individuals should be allocated a "base" or minimum payment, only for those enrollees with high risk characteristics should a health plan receive additional risk adjustment transfers.

Brief Actuarial History of Risk Adjustment

Health plan actuaries have been using various forms of risk adjustment for years for pricing premiums for health insurance coverage. Age/sex rating, experience rating, and tier rating have been components of the methods used to determine premiums to be charged for a specific category of individuals. The insurance industry's practice of health underwriting has been based on the ability to appropriately project next year's costs based on current claims experience (for large employer groups), or on past medical conditions along with age and sex (for individuals), or on a combination (for small employer groups). This type of cost and illness information has been used in a way that is generally similar to how the new health risk adjustment methods operate.

Humana has had actual experience with some of the early adopters of risk adjustment methods. One of the best-designed early "natural experiments" was the Health Insurance Plan for California (the "HIPC"), a small group purchasing pool.[4] The HIPC implemented an inpatient-data risk adjuster for the 1996/97 contract year, after two years of development and simulation. Humana's small employer division, Employers Health Insurance, participated in the HIPC as one of two original PPOs and was actively involved in the design and implementation of the HIPC's risk adjustment method. Humana and the HIPC learned several lessons as we progressed from the "good idea" stage to full implementation, including:

- A full and open process between vendors (health plans) and the payment agency (the HIPC's parent, California's Managed Risk Medical Insurance Board) was very helpful in designing a practical method;
- Any new data collection process will have flaws which only "trial and error" can uncover and which can then be corrected; and
- A simulation period for a *brand new payment method* is invaluable for learning the details of the approach and for evaluating the "real world" impact (on premiums and behavior).

What HCFA Did—Right and Wrong

I will turn now to a few specific comments about the proposed risk adjustment system. In its efforts to implement a risk adjustment system, HCFA has considered and responded to several critical issues. First, HCFA realized that given a January 1, 2000 implementation date, the use of inpatient data (while imperfect) is the only practical option. Second, HCFA has adopted a prospective payment method, using

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[1] Iezzoni, LI, et al. "Paying more fairly for capitated care," *New England Journal of Medicine,* 339(26), December 24, 1998, pp. 1933-38.

[2] Medicare+Choice Rates—45 Day Notice, http://www.hcfa.gov/stats/hmorates/45d1999/45d.htm.

[3] See "Health Risk Assessment and Health Risk Adjustment, Crucial Elements in Effective Health Care Reform," Monograph Number One, American Academy of Actuaries, May 1993 for a more detailed explanation.

[4] Bertko, J. and Hunt, S. "Case Study: The Health Insurance Plan of California," *Inquiry*, 1998, 35:148-153.

a 6-month data lag. This means that payments to a health plan will be made based on information that at most is between 6 and 18 months old. Third, HCFA plans to implement the system using a "back-loaded" transition approach, somewhat limiting the degree to which health plan payments are affected in the early years of the transition period.

The system that HCFA plans to implement uses the Principal Inpatient Diagnostic Cost Group ("PIP-DCG") model, which groups diagnostic data according to expected cost.[5] This model has been extensively tested on Medicare fee-for-service data alone. However, it relies exclusively on *inpatient* hospital data; no data on services provided outside the hospital are used. There are several shortcomings to a system that uses only inpatient data, including a payment bias against Medicare+Choice plans.

Many managed care organizations have implemented programs to treat patients on an outpatient basis when appropriate. For example, Humana has developed several disease management programs for our enrollees—ranging from asthma to diabetes to complex chronic conditions to congestive heart failure. As part of these programs, our health plan enrollees collaborate with their caregivers to manage their care, often eliminating or shortening inpatient stays and improving health status. High levels of patient satisfaction are associated with these programs as well as reduced costs. When health plans implement programs that manage care and keep enrollees out of the hospital, they bear the full cost of those programs. Without such programs, enrollees would be more likely to be hospitalized, an outcome that is costly and unnecessary as the hospital may no longer be the most effective setting for such care. The PIP-DCG risk adjustment method penalizes plans that have such disease management systems because such plans will have fewer inpatient admissions.

The proposed risk adjustment system also excludes "short" hospital stays, those that are shorter than two days. In so doing, HCFA again penalizes those health plans that are able to provide treatment during a short inpatient stay. As an example, an individual with a particular diagnosis who is enrolled in Medicare FFS must be hospitalized for three days prior to discharge to a sub-acute care facility. An individual with the same diagnosis enrolled in a Medicare+Choice plan may be hospitalized for only one day, then moved to a sub-acute facility (which is not part of the inpatient hospital). The Medicare+Choice plan would not receive any additional payment for the treatment of this individual, since the patient did not have a qualifying inpatient admission.

There is a similar problem for conditions that can be treated equally well on an inpatient or outpatient basis—so called "discretionary diagnoses." In these cases, health plans are only paid if the condition is treated on an inpatient basis. While the PIP-DCG system does make some effort to exclude such cases,[6] some discretionary diagnoses are still included on the final list of diagnostic groups that lead to additional payment above the base payment amount such as many types of congestive heart failure. It is unlikely that there will be a large scale effort on the part of health plans to move care back into the hospital to increase payment. However, a very real potential effect is that health plans will be less likely to be innovative—either to invest in new disease management programs or in new technologies that would allow patients to be treated on an outpatient basis.

There are also technical shortcomings to the proposed risk adjustment system. First, there is a difference in the time period used to calibrate the PIP-DCG model and what will actually be used to pay health plans. The current model was developed using data from one calendar year to predict expenses for the immediate next calendar year (i.e., calendar 1995 data were used to predict calendar year 1996 expenses). In HCFA's 45-day notice,[7] a 6-month time lag for the actual implementation of the PIP-DCG model is described—this model will use data from a 12-month period (July 1-June 30) to predict expenses for the year beginning six months later (i.e., data from July 1, 1998-June 30, 1999 will be used to predict year 2000 expenses) using the original, "no lag" risk weights. A more appropriate technical solution would be for a different set of risk weights to be used; these weights would be calibrated to incorporate the 6-month time lag.

Another technical issue relates to the criteria that were used to determine whether a particular diagnosis would be included in the group of diagnoses that lead to increased payments for health plans. To be included, at least 1,000 beneficiaries in

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[5] Ellis, RP, Pope, GC, Iezzoni, LI, et al. "Diagnosis-based risk adjustment for Medicare capitation payments," *Health Care Financing Review*," 17(3), 1996, pp. 101-28.

[6] Iezzoni, LI, et al. "Paying more fairly for capitated care."

[7] Medicare+Choice Rates—45 Day Notice, http://www.hcfa.gov/stats/hmorates/45d1999/45d.htm.

the original sample had to have the diagnosis. Such a decision rule helps to stabilize payments in the model; however, by setting a minimum threshold, admissions with very high costs may be excluded and plans will not receive any additional payment for these very high cost cases.

Risk Adjustment Implementation Issues

There are several important issues related to the implementation of the proposed risk adjustment system. One of the reasons we are reluctant to have risk adjusted payments implemented this year is that we have received insufficient information from HCFA on the details of the risk adjustment process. For plans to have confidence in the risk adjustment system that HCFA implements, we must be able to understand the system and be able to replicate HCFA's results. To this end, we believe that HCFA must disclose all of the formulas used in the risk adjustment process—we cannot replicate results given with the information we have received thus far.

To date, HCFA has not disclosed all of the formulas used for the various components of the risk adjustment process even though plans have asked for this information for several months. As one example, a re-scaling factor is used to transform the current AAPCC county ratebook into the new risk county ratebook that forms the basis for calculating an individual's risk-adjusted payment. Thus far, HCFA has only provided a brief description of this formula—not all the components of the formula. Months ago, the American Association of Health Plans (AAHP), the industry's trade association, and others submitted to HCFA a list of desired information that would allow plans to make the same kinds of calculations that HCFA is making. A summary of the types of information needed is included in one of the attachments to this testimony.

HCFA has indicated that when it does release data to the health plans on March 1st, it will do so on a summary basis. Again, this will not allow plans to compare their own results with those of HCFA—the plans need individual data to determine whether they are using the same data and whether they are applying the risk adjustment technology appropriately. We understand that HCFA has faced a daunting time schedule in attempting to implement a risk adjustment system for January 1, 2000 and believe that they could do more to disclose relevant information to health plans if they had more time.

Many of the key implementation issues relate to the gathering, transmission, and analysis of data. Each health plan submits its data to a fiscal intermediary, which in turn submits the data to HCFA. To date, plans have not been able to confirm that the data submitted to HCFA are being transmitted, received and used correctly or whether there are other systems' issues HCFA has identified. If there are HCFA or fiscal intermediary systems problems that need to be fixed, plans are concerned those fixes may be delayed due to Year 2000 compliance issues. There may be as yet undetected problems in the data transfer process, potentially leading to incorrect payments to plans.

While Humana is generally pleased with the performance of its Fiscal Intermediary, Palmetto Government Benefit Administrators, we have had to work out several time-consuming processes to understand the nature of the Medicare FFS edit "error messages" that became part of the process. This happens, we believe, because HCFA is forcing the "square peg" of managed care data into the "round hole" of a Fiscal Intermediary's FFS information system. Here are just a few of our issues:

- Inability to obtain a relevant list of error codes. If we had obtained a list *with the coding logic that creates an error message,* we would correct the problems at the source of the error and avoid further submissions with these so-called errors.
- The Fiscal Intermediary provides errors grouped in an almost useless format—by provider. We need to have a more "user-friendly" or managed care-relevant error report—such as returning our own list with the error reason annotated in the same format.
- There are a *lot of claims*—Beginning March 1, we will be submitting encounter data in batches of 11,000 every two weeks—because of capacity constraints at the Fiscal Intermediary. Humana is being forced to build a special program just to organize the error list electronically to allow reconciliation and correction.

The HCFA contractor that combines all of the Fiscal Intermediaries' claims has its own turnaround and through-put issues. As reported to me by our staff, error edits can take between one day and three weeks for each batch. The process of informing us of errors is incredibly inefficient, as demonstrated by the following:

- The HCFA contractor "kicks out" one error at a time on a claim and then returns it. When corrected for that specific error, the contractor may then find another

error on the same claim and return it again. This process is repeated until all codes on a claim have been accepted.
- Each separate error requires a new claim line, which then clogs up our claim system with unnecessary claims history.
- We cannot obtain the logic behind the edits to identify and fix the source of the errors and are forced to continue this awkward, time-consuming, and costly process. This is just one example of where resources are used for unnecessary administrative costs rather than for patient care.

There are related problems with HCFA's own system (Common Working File). We received a 22,000-page report to be reconciled. Although most of these claims were accepted, we understand that some of the remainder may have "disappeared."

These are just a few examples of our frustrations and concerns about the start-up phase of this new data collection process. While HCFA has made a valiant attempt to prepare for start-up, there are still too many unresolved issues. Among them, our Chief Financial Officer must "attest" to the accuracy of our data submissions. He takes this responsibility seriously and is greatly concerned about the remaining problems. Second, any loss of data unfairly penalizes health plans since most hospital admissions create additional payments for sick members. Missing data means reduced payments in 2000. Each qualifying missed claim represents approximately $1,900 to $26,500.

Phase-In of Risk Adjustment

HCFA included a phase-in schedule for the risk adjustment system. A transition approach has a long history in the Medicare program—such rules were used for the implementation of Medicare's Prospective Payment System (PPS) and Resource-Based Relative Value System (RBRVS). During the transition for PPS, for example, hospitals received a blend of a hospital-specific payment rate and a Federal payment rate. In the first year of the transition, hospital payments were more heavily weighted toward the hospital's own costs, while toward the end of the transition, hospital payments were more heavily weighted toward the Federal payment rate.[8]

Effects of Risk Adjustment

As many Subcommittee Members and staff may know from a HCFA briefing on January 14, 1999, *preliminary* estimates by HCFA analysts indicate that HCFA's fully phased-in PIP-DCG risk adjuster would reduce payments to health plans for the 195 plans that were measured.[9] It must be noted that a risk adjustment method can be designed to be budget-neutral; HCFA, however, has released a method that apparently is intended to reduce payments to health plans even further than intended by Congress.

There are two main issues related to the impact on health plans: (1) Should the new risk adjuster be budget neutral? and (2) Are the results of PIP-DCG risk adjustment method biased because of the reliance on only inpatient data?

Although HCFA analysts and other researchers[10] have previously submitted studies using Medicare Fee For Service data indicating concerns about overpayment of health plans in excess of 10%, HCFA's own impact assessment *using actual preliminary health plan data* showed a payment reduction of 7.6% for a typical month. Because this analysis used the initial submission of somewhat incomplete admission data, the actual payment reduction impact is likely to be less than 7% with better data. Reducing the PIP-DCG method's biases would likely eliminate more of the preliminary estimate of overpayment.

Some or all of this overpayment issue has already been addressed. Implementation of a risk adjuster that is not budget-neutral would be the *sixth* reduction in payment to health plans relative to FFS Medicare. The first reduction is the long-established 5% reduction in the payment to health plans relative to the average FFS payment—a reduction that is continued through use of the 1997 county ratebooks under the BBA. This reduction was originally made to assure savings in the Medicare Risk program. The second reduction is the five year phase-in of a "growth reduction" of 2.8% under BBA, which is an arbitrary payment reduction. The third reduction, while not intended as a reduction, is related to decreasing the geographic payment disparity between high and low cost counties which affects counties where the majority of beneficiaries reside. The fourth reduction is reduced payments to

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[8] *1986 Annual Report to Congress: Impact of the Medicare Hospital Prospective Payment System,* Health Care Financing Administration, May 1989.

[9] Presentation to Congressional staff by the Health Care Financing Administration on January 14, 1999.

[10] Brown, R.S., Bergeron, J.W., Clement, D.G., Hill, J.W., and Retchin, S.M., "Does Managed Care Work for Medicare? An Evaluation of the Medicare Risk Program for HMOs," Princeton, NJ: Mathematica Policy Research, Inc., December 1993.

FFS providers—an indirect reduction—and the fifth reduction, also not intended to be a reduction, is the unfair imposition of a "user fee" to cover the cost of beneficiary education materials for *all* beneficiaries—not just those in managed care. Finally, HCFA has proposed a risk adjustment implementation that further reduces payments to Medicare+Choice contractors, rather than using risk adjustment to allocate proper funding to health plans that enroll sicker members. *We strongly recommend that risk adjustment be implemented on a budget-neutral basis to avoid "double jeopardy" of multiple payment reductions.*

The other major issue is the bias against managed care health plans through use of HCFA's version of the PIP-DCG method. There are several areas where this bias will have an effect on payments. The following are examples:

- *HCFA's elimination of "short stay" admissions from the PIP-DCG model payments.* Humana, like most Medicare+Choice contractors has successfully reduced the length of stay at acute facilities. The elimination from payment "scoring" of hospital stays of less than two days penalizes health plans that have reduced hospital costs. For Humana's senior and disabled members, 22% of hospital visits were in the "short stay" category, based on a recent study. While many of these stays will be for less serious conditions, the effect of the elimination was approximately a 1.5% reduction in payment. In contrast, there is much less incentive in Medicare FFS to achieve significant reductions in length of stay given Medicare's requirement of a 3-day stay prior to discharge to a sub-acute care facility.
- *HCFA's inclusion in PIP-DCG payments of certain conditions that are more commonly treated in FFS medicine by an inpatient admission.* There is a wide variation in treatment practice across the U.S.[11] and great efforts by health plans to appropriately treat members in the lowest cost setting. Since this setting is more frequently an outpatient clinic or physician office, conditions that are "site-of-treatment discretionary" should be moved to the "base" payment category, so health plans are not penalized (by failing to trigger additional payments associated with a PIP-DCG group) through shifting patients to these less expensive ambulatory sites. Using definitions of discretionary conditions from an older study by members of the DCG research team,[12] our consultants found that keeping these discretionary conditions in the PIP-DCG model could reduce payments to health plans by 1% to 3%.
- *A perverse incentive created by use of only inpatient admissions rather than more complete diagnostic data.* Humana recognizes the practical need to begin risk adjustment with only inpatient data. While pragmatic issues may mandate the use of an inpatient data method at the start, health plans should not be penalized at every decision point. If some of the biases can be corrected, then health plans will be paid more appropriately for providing care in a cost effect manner.

We would point out that this practical approach penalizes the "good deeds" that health plans accomplish, such as preventing heart conditions. For example, Humana has over 3,900 members in a disease management program to prevent or reduce Congestive Heart Failure (CHF). Our specialists estimate that 60% of admissions linked to CHF can be eliminated—therefore, we hope to eliminate all admissions next year for 2,300 of the 4,000 seniors in the program. However, if all these members are Medicare+Choice members, we will then lose about $12,000 per admission by not triggering the additional payment for PIP-DCG 16—for a total of about $28 million. On a per-person basis in the region affected, reimbursement would be reduced by about $100 per member per year. We may need to reduce members' prescription drug benefits by nearly 33% to offset this revenue loss.

Possible effects of inappropriate implementation of risk adjustment on our Medicare+Choice enrollees could be significant. While the phase-in reduces concerns in the first year, the amount of payment reduction *that may be incorrect* in the second year is frequently greater than a health plan's entire profit/surplus margin. One or more consequences will occur: health plans will reduce supplemental benefits, premiums will be charged or increased, or health plans will exit counties that are currently marginal or difficult markets. The recent study in *JAMA* about "spillover"

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[11] Wennberg, J.E., Freeman, J.L., Shelton, R.M., and Bubolz, T.A., "Hospital Use and Mortality among Medicare Beneficiaries in Boston and New Haven," New England Journal of Medicine, 321(17):1168-73, October 26, 1989.

[12] Ellis, R., and Ash, A. "Refining the Diagnostic Cost Group Model: A Proposed Modification to the AAPCC for HMO Reimbursement," February 1988, report prepared for the Health Care Financing Administration.

effects of Managed Care points out the savings that would be eliminated from FFS Medicare without the beneficial presence of health plans.[13]

Administrative Cost Concerns

The cost of adapting to risk adjustment is just one of many administrative costs resulting from the Balanced Budget Act (BBA). Although Humana has begun to estimate these costs, we continue to collect and submit new data, adapt our rating and budget processes, revise provider contracts, products, enrollment systems and communication materials, collect data for newly mandated clinical studies and train providers and staff. To provide some idea of the magnitude of the administrative costs, we turn to the issue of provider contracting. Humana has over 128,000 separate providers of all types—physicians, hospitals, labs, DME vendors, etc. Because of BBA changes, we are in the process of re-contracting with a significant number of those providers—providers in whose offices we are concurrently auditing medical records for the purposes of HEDIS and clinical studies and securing data to meet regulatory requirements for physician incentive arrangements. The average cost of just re-contracting runs about $34 per hour and 3 hours of effort, for an average contract cost of roughly $100. Including the costs for drafting and regulatory agency filing of contract forms, we estimate provider re-contracting costs will exceed $3.2 million.

Beyond risk adjustment, the HCFA's BBA regulations have imposed extensive new requirements for oversight, additional clinical studies for quality measurement, and other compliance requirements. As an example, the two required Medicare clinical studies for each Humana Medicare+Choice plan requires an expenditure of $75,000 per plan for data collection alone. Current accreditation costs for Humana requires an expense of between $300,000 and $1.5 million.

Request for Deferral of Risk Adjustment

We would ask that risk adjustment using inpatient data for the Medicare+Choice program be deferred for at least one year due to lack of disclosure of necessary methodological and formula-related information to plans, data collection issues, known and unknown HCFA and Fiscal Intermediary systems issues and the potential adverse effects this payment method could have on beneficiaries and health plans. To date, health plans have submitted detailed claims data to HCFA and HCFA is in the process of analyzing those data. As you may know, due to provisions in the Balanced Budget Act of 1997, Medicare payments to health plans have increased in many counties by only 2% in the previous two years, a level below the cost increases that many health plans have experienced. As a result, increased payment uncertainty due to a new risk adjustment system will exacerbate what is already a difficult situation for many health plans. Some plans have already decided to discontinue participation in the M+C program in one or more counties. In spite of the phase-in of risk adjusters, it is likely more plans will go this route in the next two years if the PIP-DCG risk adjustment system is implemented on the current schedule.

As an alternative to implementation of the proposed system on January 1, 2000, we suggest that over the next year, HCFA continue to analyze data submitted by the health plans and conduct a simulated risk adjustment. This would allow hospitals, health plans, HCFA and its contractors enough time to improve their data reporting systems so as to ensure proper payment. A similar timeframe for implementation was used in California for the Health Insurance Plan of California (HIPC), a small-group purchasing cooperative.[14] We strongly believe that a simulation of risk adjustment over the next year would provide invaluable information to participating health plans and to HCFA.

Conclusion

Humana supports the move towards a risk-adjusted payment system but only after several key risk adjustment method issues are resolved and data collection processes are improved significantly. We urge you and HCFA to defer implementation of the new risk adjustment system for at least one year to allow this improvement. We understand that HCFA faced a daunting schedule and believe that the Agency could do more to disclose relevant information to health plans if it had more time. As an alternative to implementing the proposed system on January 1, 2000, we suggest that over the next year, HCFA continue to gather and analyze data submitted by the health plans, conduct a simulated risk adjustment, and work towards

[13] Baker, L. "Association of Managed Care Market Share and Health Expenditures for Fee-for-Service Medicare Patients," *Journal of the American Medical Association,* 1999, 281: 432-437.
[14] Bertko, J. and Hunt, S. "Case Study: The Health Insurance Plan of California."

improving the entire data process. This would allow all parties sufficient time to improve their data reporting systems so as to ensure proper payment. We strongly believe the additional time would allow health plans and HCFA to obtain valuable experience and information, allowing all to have greater faith that the new risk adjustment system is an improvement and is being implemented correctly.

This concludes my prepared testimony. I would be happy to answer any questions you may have.

Request for Data to Understand HCFA's Proposed PIP-DCG Risk Adjustment Method

Risk adjustment is correctly recognized as a *major change* in payment methodology. As such, all components of the method must be fully understood by health plans as well as HCFA. At this point, the *conceptual* components of the method have been published and are beginning to be understood. However, many of the calculations and much of the underlying data remain in the "black box" used by HCFA. The HMO industry requires access to all of the calculations and data, including access to all of the demographic data now used (e.g., data on the new "originally disabled" status), diagnostic data needed to create the PIP scores and the calculations which create the "re-scaling" factors needed to convert the current AAPCC county ratebook into the new county "risk" ratebooks.

Data, Formulas and Examples Required

The following data, formulas or examples are needed to fully work through the risk adjustment method and its implementation process:

1. HCFA should provide a *detailed* illustration of every formula and calculation used to determine the results of applying the risk adjustment method. For example, HCFA should provide examples of calculations for health plans in five counties (e.g., large urban county, suburban county, rural county, and very small rural county) showing exactly how the rescaling factors are calculated and how the risk scores of illustrative health plans would be calculated.
2. HCFA should provide detailed descriptions of how the various BBA provisions (e.g., the floors, blend, removal of GME and budget neutrality) will apply to the two separate rate books (the "old" AAPCC and the new risk ratebooks) and provide examples of when one ratebook would replace another (e.g., if the floor using the new risk ratebook would be larger than the floor using the old AAPCC ratebook).
3. HCFA should provide *access* to all the Fee For Service demographic information in a county (in a confidential format) so that health plans can replicate the rescaling factor calculations. This would include providing appropriate designation of "originally disableds," Working Aged, Medicaid eligibles (under both the old and new rules) and institutionalized (under the old AAPCC rules) in a format that would allow health plans to calculate the old county ratebook portion of the rescaling factor and the demographic components of the new county risk ratebook.
4. HCFA should provide *access* for several counties (e.g., 10 counties in various geographic regions) to the full diagnostic data that were used to calculate the PIP-DCG scores for those counties. While this data may be part of the very large 100% Medicare FFS data set that is available, providing the 10-county amount in a useable format and size would be very helpful. In addition, it would be useful to have HCFA provide the actual calculation illustrations for each of the 10 counties (i.e., the distribution of PIP-Groups and diagnoses as an intermediate step to allow confirmation of the results).
5. HCFA should provide *access* to *all* of the demographic data *of a health plan's own members* required to compute the PIP-DCG scores under the new method. At this time, health plans do not have access to records regarding "originally disabled" status and prior Medicaid status (in some cases, such as recent enrollees). In addition, Working Aged status is generally not well-documented. We would like to obtain a better idea of how the Working Aged files are maintained.
6. HCFA should provide any impact analysis of removing short stays (i.e., admissions of less than two days length) and a list of diagnoses that are disproportionately affected.
7. HCFA should provide detailed illustrations and data for the development of the "new beneficiary" category of payment factors.
8. HCFA should provide more detail about the kinds of data transmission and analysis problems that have emerged for each health plan's data submission. Because of anecdotal evidence, many health plans have concerns that data were submitted, collected, transmitted or analyzed in an inadequate manner. To date,

the very brief summary letter mailed by HCFA on December 11, 1998 is somewhat helpful in understanding the magnitude but of very little help in finding and focusing on one-time or systematic problems.

9. HCFA should provide a briefing on any data backlog problems that have surfaced at any of the six Fiscal Intermediaries, at HCFA's risk analysis contractor or at the agency itself.

The following chart provides a summary indication of the kinds of data and calculation illustrations still likely to be needed after March 1st.

Data and Information Needed from HCFA for Risk Adjustment Analysis

Data/Information Needed	Available 1/15?	Available 3/1?	Available 1/1/2000?
Detailed description of every procedure and step of risk adjustment calculations used by HCFA.	No	No	No
Detailed description and examples of how HCFA is interpreting BBA provisions for floors, blending, 2% min. etc.	No	No	No
Electronic data file for all FFS demographic data for each county, including Medicaid, institutional, originally disabled, and Working Aged statuses to allow checking of the demographic portion of the re-scaling factor.	No	No	No
Electronic file for all FFS members PIP scores to allow checking of the risk portion of the re-scaling factor.	Partial—only provided county relative risk scores; may need to have an audit procedure.	N/A	N/A
Electronic data file for demographic data for all health plan members for each county, including Medicaid, institutional, originally disabled, Working Aged statuses.	No	Summaries only—perhaps.	A member-by-member PIP and demographic score for currently enrolled members
Impact analysis of eliminating one-day stays: types of diagnoses eliminated and the impact.	May be able to analyze and try to assess.	No	No
Detailed description, data and examples to allow health plans to replicate calculation of the re-scaling factors.	No	No	No
More detailed information about data problems and quality of data (e.g., comparisons of frequencies of diagnoses) for health plan submitted data.	No, other than the 12/11/98 letter	No	No
Information about backlog and transmission problems at the Fiscal Intermediaries or into HCFA systems.	No	No	No
Detailed description of the method and calculations used to determine the ''neutral'' demographic factors for new Medicare entrants.	Very short description provided.	No	No

Mr. BILIRAKIS. Mr. Bertko, please proceed, sir.

STATEMENT OF JOHN BERTKO

Mr. BERTKO. Good afternoon, Mr. Chairman and members of the committee. My name is John Bertko and I appreciate the opportunity to provide you with information about my experience with risk adjustment using HCFA's proposed Principal Inpatient Diagnostic Cost Group or PIP-DGC method.

I am a Principal with Reden and Anders, an actuarial consulting and data analysis firm which is part of Ingenix, the information division of United Health Group. Over the past year, Reden and

Anders has analyzed the affects of risk adjustment for many clients, including 15 large Medicare+Choice Contractors operating in 40 markets. I will be drawing upon that experience today to provide an actuary's perspective on the effects and issues associated with the proposed risk adjuster.

In my opinion, risk adjustment using diagnostic data represents a step forward in making appropriate payments to Medicare+Choice Contractors. Technically, payments using health risk adjusters are somewhat more accurate than the current method. With a risk adjusted system, health plans will be paid more for individuals with health problems and less for healthy individuals.

Also, use of risk adjustment helps achieve the policy goal of better matching payment to the needs of the covered population. Under this PIP-DCG method, most enrollees will be assigned to the healthy or base category. This means that health plans will receive a base payment amount of approximately $5,000. Then HCFA will analyze each enrollees medical encounters over the previous year to see if that enrollee had an admission that falls into one of the 15 PIP-DCG categories that increase payments.

A qualified in-patient admission then creates a PIP score that is worth from $2,000 to $26,000 more in additional payments. Now, because the PIP-DCG method relies exclusively on in-patient data, as mentioned by most speakers today, it should be considered only a first step. Analysts and Actuaries recognize the bias inherent in a payment method that uses only in-patient data since payments to health plans are reduced for keeping members out of the hospital.

However, in an in-patient data method is really the only practical first step and should be acceptable, but only if implemented with care. While I believe that the overall design of the PIP-DCG model is appropriate, there are several components of the model that should be re-examined because of unnecessary payment bias. As one example, HCFA and others have talked about that the decision to eliminate short stays, that is admissions of less than 2 days.

Thus if a person with a heart condition is treated during a 1-day hospitalization and then sent to a sub-acute facility, no payment other than the base payment is made. In fee-for-service Medicare it is much more likely that this person will be hospitalized for 2 days or more adding to the payment bias. The second example involves conditions that can be treated either on an in-patient basis or an out-patient basis, such as a physician office or clinic.

Again, for any treatment that occurs in a non-hospital setting, health plans will not receive any payment over the base amount. An option would be for HCFA to remove some of these discretionary conditions from the PIP-DCG model to reduce the payment bias. Next, one of an Actuaries professional requirements is that he or she be able to replicate the results of another Actuary's work. At this point, I am unable to say that I can perform a thorough replication of HCFA's work.

I agree with all of Mike Hash's statements earlier, but I strongly recommend that HCFA produce full disclosure and have open discussions with health plans and other interested parties about more of the details. This involves disclosing all of the formulas used for every component in the model and the research reports used to cre-

ate the model. Health plans need to be able to fully test and understand the model's operation. Last, implementation of the PIP-DCG model requires creation of a new data transmittal an analysis process.

In this process, encounter data must be handed from hospitals to health plans to fiscal intermediaries to HCFA like a runner's baton. If this data baton is dropped anywhere along the way, health plans then are automatically penalized through payment reductions. There are many opportunities for errors and break downs in the system. These include hospitals delaying correction of in-patient data errors. Plans having difficulty gathering data from capitated providers who pay their own claims.

And many of the fiscal intermediaries having awkward or very slow procedures in place to identify and report errors. My experience as an Actuary in California, with Colorado, with Washington State, is that risk adjustment can be done correctly by taking the time necessary to have all the components working right.

In summary, risk adjusted payments represent an improvement over the current payment method, but only if the practical data issues are first addressed and several components of HCFA's model are re-examined. HCFA staff are really to be commended for their hard work and moving toward implementation on such a demanding timetable. I suggest, however, that implementation not occur until HCFA and the health plans are satisfied that all the data issues have been addressed and that several of these biases are re-examined and removed. Thank you.

[The prepared statement of John Bertko follows.]

PREPARED STATEMENT OF JOHN BERTKO, PRINCIPAL, REDEN & ANDERS, LTD; SAN FRANCISCO

Good Morning, Mr. Chairman and Members of the Committee. I appreciate the opportunity to provide you with information about my experience with risk adjustment for health plans using the Principal Inpatient Diagnostic Cost Group (or PIP-DCG) method. I am a consulting actuary and Principal with Reden & Anders, Ltd., an actuarial consulting and data analysis firm, which is part of Ingenix, the information division of United Health Group. Reden & Anders' risk adjustment clients include 15 large Medicare+Choice contractors with operations in nearly 40 diverse markets. Over the past year, we have been analyzing data from our clients, in an effort to help them better understand how their payments for Medicare enrollees will change as a result of the implementation of a risk adjustment system. I will be drawing from this experience and providing an actuary's perspective on the effects of and issues associated with the proposed PIP-DCG risk adjuster.

Risk Adjusted Payments Are an Improvement over the Current Method

In my opinion, risk adjusted payments using diagnostic data represent a step forward in making appropriate payments to Medicare+Choice contractors. Technically, a payment system using health risk adjusters is somewhat more accurate than the current payment system. This is especially true for groups of individuals with more health problems—in most cases, health plans will spend more to treat these individuals and, as a result, deserve higher payments. Similarly, for groups of healthy individuals, risk-adjusted payments to health plans will be appropriately reduced. Use of risk adjustment also helps to achieve the policy goal of better matching payment to the needs of a covered population.

In any diagnosis-based risk adjustment method, each individual is assigned a "relative risk score" based on his or her past illness history. In comparison with the average risk score of 1.00 for an entire population (both sick and healthy individuals), someone with a heart condition may have a relative risk score of 3.0, which means we expect the person to have expenditures that are three times the average next year. By contrast, a healthy 70 year-old male may have a risk score of .70, meaning that we would expect his expenditures for the next year to be only about 70% of the average of the group.

Under the PIP-DCG method, most enrollees (i.e., those who do not have a qualifying inpatient stay) will be assigned to the "healthy" (base) category. This means that health plans will receive a base payment amount (approximately $5,000 for these individuals). The base payment varies by age and gender, as well as by disability, welfare, and working aged status. HCFA will analyze each enrollee's medical encounters over the previous year to determine whether the enrollee had an admission that falls into one of the 15 PIP-DCG categories with increased payments. An inpatient admission creates a PIP-DCG score that is worth from $2,000 to $26,000 per year in additional payments.

Because the PIP-DCG method relies only on inpatient data, it should be considered a first step, or a "Work in Progress," but an important improvement over the current method—which uses only age, gender, and status (disability, institutionalization, welfare or Working Aged status) for payments. Other methods that use data from both the inpatient and outpatient settings ("full" data methods) are under development and are being used in some settings (e.g., by the Buyers Health Care Action Group in Minneapolis). HCFA has indicated that it plans to use both inpatient and outpatient data for risk adjustment beginning in 2004.

Analysts and actuaries recognize the bias inherent in a payment method that uses only inpatient data, since Managed Care plans are penalized for keeping members out of the hospital. However, an inpatient data-based method is the only practical first step and should be acceptable, if implemented with care. The inpatient method should also be thought of as a natural transition to a method that uses both inpatient and outpatient data. This is because the relative risk scores that are calculated using only inpatient data are, generally, closer to the average for the group (1.00) than risk scores calculated using "full" data methods, thus reducing the effects on payment to health plans. On the other hand, health plans that successfully treat high-cost conditions in an ambulatory setting will be penalized, since no additional payment will be provided for high-cost individuals who have not had an admission.

PIP-DCG Model Still Needs Refinement

While I believe that the PIP-DCG model overall is well-designed and has been tested extensively on the Medicare population, there are several components of the model that should be re-examined. As noted above, any inpatient-data risk adjuster will be biased against Managed Care plans because of their ability to eliminate some inpatient admissions. Although this circumstance must be accepted during a transition phase, other components of the HCFA model add to this bias. As one example, HCFA has chosen to eliminate "short stays" or admissions with a length of stay of less than two days from contributing to an enrollee's risk score. Thus, if a person with a heart condition is treated during one day and then sent to a Skilled Nursing Facility, the health plan will receive only the base payment for that enrollee, since the enrollee did not have a qualifying inpatient admission. In FFS Medicare, it is much more likely that this person will be hospitalized two days or more, adding to the payment bias. Similarly, there are other conditions that can be treated either on an inpatient basis or an outpatient basis (in a physician office or clinic). Again, for any treatment that occurs in a non-hospital setting, health plans will not receive any payment over the base amount. The result would be that the relative risk scores for enrollees in Managed Care plans would be lower than the relative risk scores of Medicare FFS enrollees. One way to address this problem would be for HCFA to remove some of these conditions from the PIP-DCG model.

HCFA Needs to Disclose Data and Methods

One of an actuary's professional requirements is that he or she be able to replicate the findings of another actuary's work. To date, we have analyzed data for our clients, using our "best guess" regarding the various formulas and components of the PIP-DCG Model. Therefore, at this point, I am unable to perform a thorough replication. I strongly recommend that HCFA provide full disclosure and have open discussions with health plans, consultants, academics, and other interested parties. This involves disclosing all of the formulas used for every component of the model, as well as providing access to data in HCFA's files about beneficiary status and health conditions so that health plans can test and fully understand the model's operation.

Implementation Issues

Implementation of the PIP-DCG payment method has required the creation of a new data transmittal and analysis process. As part of this process, encounter data must be handed from hospitals to health plans to Fiscal Intermediaries to HCFA or its contractor. If the "data baton" is dropped anywhere along the way, then health plans are penalized automatically through lower payments. For example, sometimes hospitals make mistakes regarding an inpatient admission and attribute it to the wrong health plan. We have heard reports of hospitals delaying correction

of errors, with the result being that health plans cannot submit corrected encounter records. Some plans may have difficulty gathering data from capitated providers who pay their own claims. Many of the Fiscal Intermediaries have awkward or slow processes in place to identify and report errors. As a result, health plans can spend an inordinate amount of time trying to fix errors. If the Fiscal Intermediaries were more forthcoming with what triggered errors, the health plans could correct the errors before submitting data to the Fiscal Intermediaries. HCFA has at least a few small problems in its systems for making use of encounter data. With the lack of sufficient feedback on the data errors, health plans are unable to confirm that data being used by HCFA matches their internal records.

Summary

Risk-adjusted payments represent an improvement over the current AAPCC payment method, but only if practical data issues are first addressed and several components of HCFA's PIP-DCG method are re-examined. HCFA staff are to be commended for their hard work in moving towards implementation on such a demanding timetable. I suggest that implementation not occur, however, until HCFA and health plans are certain that all biases are removed from the model and important data process issues are corrected.

Mr. BILIRAKIS. Mr. Johnson.

STATEMENT OF KIRK JOHNSON

Mr. JOHNSON. Thank you, Mr. Chairman and members of the committee. I am Kirk Johnson, Senior Vice President of CNA Health Partners, a subsidiary of a multi-line insurance carrier, CNA. I am testifying today on behalf of the Health Insurance Association of America, which CNA is a member. HIA members include companies currently serving as Medicare+Choice carriers, companies who are considering doing it and companies who have withdrawn from the program.

Although CNA has a significant involvement in health care, it is the largest professional liability insurer in the country and we administer the second largest of the Federal employee health benefit plans, the Mailhandlers Plan. CNA does not itself have a Medicare Risk Plan or Medicare+Choice product. CNA Health Partners, however, is a management services organization, a partner for doctors, hospitals and integrated delivery systems who have become Medicare Risk Plans as HMO or who take downstream risks from other risk plans and Contractors like those here today, or who desire to become PSO's, Provider Service Organizations.

PSO's, as you know, were created by the Balanced Budget Act of 1997. They were supposed to offer to Medicare beneficiaries a competitive alternative to traditional HMO's and to fee-for-service providers. The Medicare+Choice law has not yet done what it is intended to do. It has not created more competition or more choices for Medicare beneficiaries. It has not yet rationalized the payment mechanism so that there is predictability and fairness.

It has not yet made it possible for doctors, hospitals and integrated delivery systems to directly contract with HCFA to offer their own plans. Indeed, the Act has made it less likely that they will subcontract on a risk basis with existing plans today. The reason is only partly concerns about the risk adjustment formula, although we have them. In fact, behind me are charts which show how the disparity in payments to fee-for-service versus risk plans will grow by 2003 under the current formula.

The primary reason providers are not in this business are the very ones which you have heard from the established national Medicare risk plans. It is difficult for the government to be both

a purchaser and a regulator. It cannot pay less than the rate of medical inflation on the one hand, and at the same time add significant new regulatory requirements, procedures and restrictions on a plans ability to make essential market adjustments.

No one would expand into or enter into this market. It is particularly unlikely that providers will do that. Providers, doctors and hospitals do not have either the scale, the big networks or the sophisticated claims and information infrastructure of the national plans. There were less than a handful of PSO's under the new BBA provisions last year.

Congress and the regulatory system gave PSO's very little help. In fact for many providers, and we represent a substantial number of them who have PSO aspirations, the program appeared to be going backwards. For example, the mandated expedited appeal procedures which entitle every Medicare beneficiary to a formal appeal virtually any time he or she disagrees with a physician's treatment recommendation.

It turns a common medical matter for which a second opinion would be an obvious remedy, into an expensive, administrative, legal adversary one. The requirement that every detail of a plan be approved and then frozen well in advance of the effective date. What will amount to, on the average, of 2 percent reimbursement increases for most plans at a time when medical inflation is three times that. Finally, the important and necessary risk adjustment for providers is particularly necessary.

Providers are going to attract patients who know them best, the sick ones. But it should not be done in a way that reduces overall reimbursement, and it should not add substantially to the already serious regulatory burdens on them. Health care costs are going to go up, perhaps dramatically. There is no way and it would be immoral if not illegal to do so, to manage out of the system the ever-growing technology gains that save life and enhance its quality, even though they will inexorably add to the cost.

Creating new competitive alternatives as the BBA did, was the right approach. Particularly the opportunity for providers to accept financial accountability, directly or in partnership with the plans. I think most would agree that doctors, now the ones who are licensed to practice medicine, will have to find the next round of savings and efficiencies in medicine. They can do it now because of the innovations in medical technology and the incentive to take financial accountability, but they have precisely the same concerns about the execution of the BBA as the existing Medicare Plans have. Thank you.

[The prepared statement of Kirk Johnson follows.]

PREPARED STATEMENT OF KIRK JOHNSON, SENIOR VICE PRESIDENT, CNA HEALTH PARTNERS, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman and members of the Committee, I am Kirk Johnson, Senior Vice President of CNA Health Partners. I am testifying today on behalf of the Health Insurance Association of America ("HIAA"). As the preeminent health insurance trade association, HIAA is the principal voice of the broadest spectrum of the health insurance industry. HIAA represents over 265 members that include commercial insurers, health maintenance, preferred provider and managed care organizations and businesses that provide products and services to the health insurance industry. Together, HIAA members provide health, long-term care, supplemental, and disability income insurance coverage to more than 110 million Americans. Association mem-

bers include companies currently serving as Medicare+Choice managed care contractors, companies who are considering offering new Medicare+Choice options, and companies that have recently withdrawn from the Medicare+Choice program, giving us a unique perspective on the issues under review by this Committee. CNA Health Partners is a company assisting new or developing Medicare+Choice organizations.

I am pleased to have this opportunity to discuss the implementation of the Medicare+Choice program with you and to share a few of our principle concerns. HIAA and CNA Health Partners believe that the Medicare+Choice program represents an essential component in the government's effort to ensure the financial survival of the Medicare program and to meet the health care needs of the baby boom generation as we move into the 21st Century. HIAA applauds the Commerce Committee for its role in shaping these bold Medicare reforms through the Balanced Budget Act of 1997. Recent developments, however, suggest that the Committee's work is not yet done. To ensure the promise of the reform, and to facilitate beneficiary choice under the Medicare program, additional legislative and policy modifications must be made.

CONCERNS ABOUT LOW ANTICIPATED MEDICARE+CHOICE ORGANIZATION PAYMENT RATE INCREASES

1. Limits on Annual Increases in Capitation Rates and Concerns Regarding the New Proposed Risk Adjustment Methodology Threaten the Continued Attractiveness of the Medicare+Choice Program to Beneficiaries and Providers.

a. Most Plans Will Experience Cost Increases From Medical Inflation That Exceed Payment Increases During the Coming Year.—Perhaps the greatest threat to the success of the Medicare+Choice program is the collective impact of changes in Medicare's payment methodology enacted by the BBA. In order to achieve a successful partnership between the federal government and Medicare+Choice organizations, program rules must: (1) allow payment rates that recognize and adjust for the actual costs of providing health care and permit necessary investment in clinical and operational improvements, and (2) incorporate financial incentives to reward those Medicare+Choice organizations that achieve the government's economic, clinical and operational objectives.

As set forth in Section 1853(c) of the BBA, Medicare+Choice organizations will be paid the greater of:

(a) a blended capitation rate, which is the sum of a percentage of the area-specific capitation rate and a percentage of the national Medicare+Choice capitation rate (the percentage balance will change over time until it reaches a 50/50 blend in 2002); or

(b) a minimum amount, which is $379.84 per enrollee per month in 1999; or

(c) a minimum percentage increase for 1998 equal to an increase of 2 percent of the 1997 Adjusted Average Per Capita Cost ("AAPCC") rate for the particular county, with increases of 2 percent in each subsequent year.

Due to a budget neutrality requirement, the blended capitation rate was not available in 1998 or 1999. The Health Care Financing Administration (HCFA) anticipates, however, that the blend will apply for the first time in the year 2000. While the majority of counties will receive blended payments, it is HIAA's understanding that approximately 30 percent of counties will continue to receive the floor amount and 11 percent of counties will receive the minimum two percent increase.

The practical result, based on actual Medicare+Choice enrollment, is that Medicare+Choice organizations serving a majority of Medicare beneficiaries enrolled in such organizations will receive rate increases of the minimum 2 percent or only slightly more. For many—if not all—of these organizations, this increase would not be sufficient to cover the increased cost of providing mandated services, given projected medical inflation [1]. This, combined with the fact that many Medicare+Choice organizations experienced significant losses in 1998 (and anticipate additional losses in 1999), forecasts trouble for the program.

Indeed, inadequate reimbursement rates largely were responsible for the retrenchment of Medicare+Choice plans last Fall. At that time, some of the most respected Medicare+Choice organizations in the country withdrew from states and counties with low capitation rates. Other withdrawals occurred in low enrollment areas even though capitation rates were above average. As reported, 42 health plans decided to withdraw from the Medicare+Choice program and 53 plans decided to cut

[1] The budget for fiscal year 2000 includes funding original fee-for-service Medicare that reflects anticipated increases in medical costs over a five year period of 27% and an increase in the Federal Employee Health Benefit Program of about 50%. Estimates of the likely growth for Medicare+Choice plans in high paying counties for the same period is less than 10%.

back their services. In all, about 400,000 Medicare beneficiaries were effected. To put this in perspective, HCFA averaged two Medicare risk contract cancellations per year from 1993 through 1997.

The use of the blended rate for some Medicare+Choice plans for the first time in 2000 is clearly a step in the right direction in terms of ensuring fair and adequate reimbursement. However, HIAA strongly believes that additional adjustments are necessary to attract and maintain the number and diversity of Medicare+Choice organizations necessary to establish a sound and attractive market-based alternative to the traditional fee-for-service program.

Accordingly, HIAA urges Congress to reconsider the artificial and arbitrary limits on capitation rate increases set forth in the BBA. Specifically, HIAA suggests that annual increases in Medicare+Choice payment rates be sufficient to fully cover medical inflation experienced in the local markets. Because local employer health plans and other commercial customers have a tremendous incentive to keep costs down, they will positively affect the inflation rate in each market. If the current reimbursement structure is not adjusted, more Medicare+Choice organizations are likely to withdraw from areas served and beneficiaries enrolled in the remaining plans will likely experience premium increases or reduced benefits. Finally, as Medicare+Choice plans leave the market, the original Medicare program (with its higher per capita costs) will have more beneficiaries and put additional strain on both the Part A Trust Fund and the budget.

b. The New Risk Adjustment Methodology Will Substantially Reduce Payments to Medicare+Choice Organizations.—Change in the Medicare+Choice payment calculations is all the more necessary because the risk adjustment process which HCFA is implementing is expected to substantially reduce aggregate payments to Medicare+Choice plans while adding additional administrative requirements and expenses. According to preliminary HCFA estimates, total Medicare+Choice plan revenues for the year 2000 are projected to be $200 million less than they would have been under the Adjusted Average Per Capita Cost ("AAPCC") payment method and $6.3 billion less in 2004. As a result, some plans will see even their minimum two—percent increase eroded in 2000 as the risk adjustment methodology is phased in. Thus, what began as a straightforward effort to more accurately compensate plans for the health care costs of their particular members will, unexpectedly, result in an overall reduction in funds to Medicare+Choice organizations.

This development runs counter to HIAA's understanding of Congressional intent, i.e., that the savings resulting from the percentage reduction[2] in plan payments for years 1998 through 2002 was intended to be *in lieu of* any net program savings from risk adjustment. (Indeed, the Congressional Budget Office did not score any projected savings in connection with the risk adjustment program under BBA 97). The new methodology, and huge projected revenue reductions, underscores HIAA's concerns regarding the inadequacy of plan payments under Medicare+Choice. To the extent that the proposed HCFA risk adjustment methodology translates into a significant overall decrease in payments for the Medicare+Choice program, it will undoubtedly be an additional deterrent to program participation. Accordingly, HIAA urges Congress to require HCFA to modify the risk adjustment methodology so that aggregate payments to Medicare+Choice plans for 2000 and beyond are based on aggregate BBA adjustments, making the risk adjustment process budget neutral.

c. The User-Fee "Tax" on Medicare+Choice Organizations for Beneficiary Education is Inequitable and Reduces Even Further Payments to Medicare+Choice Organizations.—HIAA strongly supports educating and informing Medicare beneficiaries about all coverage options, including the Medicare+Choice program, and supplying beneficiaries with straightforward, unbiased information to help them choose appropriate coverage. That said, we are concerned that the BBA, to support beneficiary education activities for *all* 37 million beneficiaries, places a "user fee tax" on Medicare+Choice organizations only.[3] The educational campaign is a benefit to all Medicare beneficiaries. Indeed, initial information suggests that the toll-free number HCFA established last year with funds from the $95 million dollar "tax" assessed upon Medicare+Choice organizations primarily fielded calls from beneficiaries seek-

[2] In addition to the 5 percent reduction in payment from fee-for-service costs which existed prior to the BBA, the increase in payment to Medicare+Choice organizations under both the blended rate and the floor will not fully reflect anticipated medical inflation. A reduction of 0.8 percent was made in 1998 and reductions of 0.5 percent are to be included in 1999 through 2002. The cumulative effect of these reductions will be that even the blended rate adjustment will be inadequate. This, coupled with the insufficient increases in the minimum rate, will undermine Congressional intent to encourage growth of Medicare+Choice options for seniors in low cost areas.

[3] Medicare+Choice organizations essentially pay a "head tax" (i.e., an amount based on the number of Medicare+Choice enrollees in their plan) to support the public information program.

ing information about the *fee-for-service program.* Considerations of equity dictate that the educational program—which informs beneficiaries about basic program benefits and requirements—be funded from the Medicare trust fund, or another broad-based source of revenue, as are other such essential program functions.

We note that this tax, which is .355% of the total monthly payments to each Medicare+Choice plan in 1999, further exacerbates the problems outlined above concerning inadequate reimbursement. Indeed, when the user fee tax is combined with potential large revenue reductions from risk adjustment, some existing Medicare+Choice plans will see little or *no* increase in their payment rates from 1999 to 2000 even though HCFA is using a phase-in of an interim risk-adjustment methodology.

The cumulative effect of these three payment reductions will vary depending upon the relationship of the current payment, current benefits, and the number of beneficiaries enrolled.

In your district, Chairman Bilirakis, there were 139,000 beneficiaries enrolled in Medicare risk plans (or 32 percent of Medicare beneficiaries). We project[4] that Medicare+Choice plans will receive only 51.4 percent or half of the increase per capita relative to Medicare fee for-service increases. We also project an increase in the 65+ population from 482,000 in 1998 to 533,000 in 2003. If Medicare+Choice options are withdrawn or have less perceived value by then, a reduction of Medicare+Choice enrollment to 75 percent of existing numbers would reduce the savings from BBA for 2003 by $77.7 million[5] from your district alone.

HIAA has calculated the impact of BBA's payment policies, including risk adjustment, for the counties of each member of this subcommittee. A composite of your district's projected payments has been delivered to your office. As examples of these projections, attached to our testimony are the projections for Chairman Bilirakis' district and Representative Brown's district.

2. The May 1 Deadline for Filing ACRs Has Created Serious Problems in the Administration of the Medicare+Choice Program and Should Be Changed to November 1.

The BBA moved the deadline by which Medicare+Choice plans must submit their adjusted community rate (ACR) proposals from November 1 to May 1. This was done in order to allow HCFA sufficient time to approve rates and include this rate information in the materials to be distributed to beneficiaries as part of the educational campaign. The problem with this time frame is two-fold. First, by submitting proposals seven months in advance of the actual effective date (*i.e.*, January 1), plans place themselves at substantial risk that health care costs will rise in unexpected ways in the latter half of the year and thus not be captured in the proposals. This is what occurred last year, contributing to the decision by many Medicare+Choice organizations to not renew their Medicare+Choice contracts for 1999, or to reduce their service areas. Also, proposals submitted by May 1st are based on relatively limited claims experience with the Medicare beneficiary population enrolled in the more rapidly growing plans and are thus less likely to be accurate predictors of costs than proposals based on a longer period of time.

Accordingly, HIAA proposes moving the ACR deadline to November 1 or as close to that date as operationally possible.[6]

In regulations published earlier this month, HCFA "recognize[d] the difficulties inherent to estimating the cost of a benefit package for 2000 based on at most 4 months of experience under the 1999 benefit package," but indicated that it had no discretion in this matter due to the statutory mandate. The President's fiscal year 2000 budget includes a proposal that would extend the deadline for ACR submissions until July 1. HCFA strongly supports this proposal. Given the importance of this issue to Medicare+Choice organizations, and the concerns involved, HIAA urges the Committee to take steps to put in place a permanent workable deadline for ACR submissions and suggests that an ACR date of November 1.

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[4] Our projections utilize September 1998 enrollment figures, a 1998 Price Waterhouse report on Medicare Capitated Payments, and reflect HCFA's assumption for the average cost to Medicare+Choice plans of risk adjustment.

[5] Lost savings, based on the difference in projected per capita payments to HCFA vs. Medicare+Choice, multiplied by the potential Medicare+Choice enrollment less 75 percent of current enrollment.

[6] We recognize that HCFA may prefer a date earlier than November 1 in order to collect information for the annual public information campaign. We believe that HCFA's public information objectives can be met while permitting Medicare+Choice organizations to submit ACRs on the old schedule. Working with third party publishers, including daily newspapers, HCFA could more than adequately distribute plan specific information to beneficiaries in a timely fashion.

3. Congress Should Return to the Previous Policy Allowing Flexible Benefits and Premiums Within a Service Area.

Historically, Medicare risk contractors were able to offer different benefit or charge structures within a given contracted service area. For example, modified benefit packages were often developed and offered in a subset of the contracted service area. While Medicare beneficiaries residing in the segmented service area were offered a uniform array of benefits at a uniform price, uniformity was not required across the entire service area. This flexibility was important because it allowed contractors to adjust their benefit package and premium structure to take into account differences in capitated payment rates received, which varied by county.

In the BBA, Congress mandated a new policy requiring that organizations offer uniform benefits and premiums throughout a service area, despite varying payment levels. Under the Medicare+Choice regulations, an organization may offer multiple plans and propose different services areas for each plan. (Were this not the case, organizations would be discouraged from expanding to outlying rural counties that typically offer lower reimbursement rates.) This regulatory policy allows Medicare+Choice organizations to achieve results similar to the original flexible benefit policy, but only at significant additional expense. Instead of one ACR being filed for a broad service area with benefits modified to reflect anticipated revenues, as used to be the case, multiple ACRs must be generated for separate Medicare+Choice plans by each organization, and reviewed and approved by HCFA. The Congressional mandate thus imposes significant administrative costs on the organizations and the agency, with absolutely no benefit to beneficiaries. Therefore, HIAA urges Congress to repeal the uniform benefits and premium provisions of the BBA.

IN MANY PLACES THE REGULATIONS ARE OVERLY RIGID AND DEMANDING SO THEY BECOME AN IMPEDIMENT TO SMALL AND/OR RURAL MEDICARE+CHOICE ORGANIZATIONS

1. The Quality Assurance Approach is Misguided.

HIAA believes that some form of quality standards are important to any market-based approach to Medicare. Without quality standards, or some other performance measurement, the added costs of maintaining quality will be difficult to present fairly although over time, it will be obvious. That being said, HIAA has serious concerns about the breadth and depth of the onerous quality assessment, performance improvement and performance measurement standards developed by HCFA.

a. Performance Measures Should Vary More by Type of Plan—As an initial matter, we believe that performance measures should be designed to fit the services offered by various types of plans. HCFA, however, has essentially embraced a "one size fits all" approach. As a result, it is unlikely that Medicare+Choice PPO plans that offer a broad choice of providers to beneficiaries (but are loosely "managed") will be able to meet the quality requirements. Similarly, the extensive quality-related requirements applied to MSA plans and private fee-for-service plans are likely to deter the necessary investment required before these types of plans can be offered. The bottom line is that the HCFA regulations are so inflexible that few options other than existing managed care arrangements with large numbers of beneficiaries can be developed. As a result, beneficiary choice will suffer, and a key goal of the Congress' work on BBA will have been defeated. In rural areas with no existing private health plan options, these regulations effectively preclude any chance that new choices will develop under most reasonable financial scenarios.

b. The Extensive Data Collection Proposed Is Not Necessary—Second, the extensive data collection and reporting efforts required under the regulations will add significant administrative costs to Medicare+Choice organization operations. We question whether these costs are justified or desirable, and whether the quality assurance goals might not be met just as well through alternative approaches. HIAA strongly believes that consumers, not government officials, should dictate through their plan choices the extent and nature of quality improvement, balanced against costs. Under this approach, organizations that are responsive to consumer preferences would be rewarded with greater market share. Fewer government resources would be required for oversight.

HCFA could, however, play a central role in ensuring that minimum standards are met and encouraging quality initiatives through flexible, incentive-based standards established by contracts. HCFA is to be congratulated for posting beneficiary satisfaction survey results and other such information on the Medicare internet site (www.medicare.gov). In HIAA's view, this would be far superior to the current practice of setting detailed regulatory mandates which run the risk of leading to micromanaging and encouraging uniformity at the price of creative experimentation.

In trying to determine the cost of the extensive data collection effort proposed, HIAA notes that many health care organizations, particularly those with loosely

managed network-style delivery systems (such as PPOs) do not currently have the capability to capture or report performance data at the level being proposed. The BBA's limitations on increases in capitation rates means that outside sources will be required to fund system upgrades. Even if financially possible, the time required for procurement, installation, training, and validation are not consistent with HCFA's scheduled implementation and reporting requirements for Medicare+Choice plans. As a result, these quality assessment requirements will be a significant deterrent to expanding senior's choices as potential new plans decide not to participate in the Medicare+Choice program. At the very least, HIAA believes that organizations making a good faith effort to meet the regulatory requirements should be provided a transition period where penalties would not be imposed. This is particularly important given plan efforts to address Year 2000 computer issues.

c. The "Deemed Status" Program Should Be Implemented Immediately.—Most Medicare+Choice organizations already adhere to rigorous quality assurance review by nationally accredited health care organizations. HCFA has provided by regulation that Medicare+Choice organizations may be "deemed" to meet quality assessment and performance improvement requirements if judged to do so by a national accreditation organization approved by HCFA and applying HCFA's standards for assessing compliance. This approach has much merit. It would allow plans to work with reviewers who already are familiar with their operations, creating obvious efficiencies and potential cost-savings. HCFA has failed, however, to establish procedures to implement the "deemed status" process. To date, HCFA has not designated any national accreditation organization for this purpose, nor has it issued policy guidance on how this process will work. HIAA urges Congress to direct HCFA to promptly institute a procedure for awarding deemed status since this process has the potential to reduce some of the substantial costs associated with HCFA's extensive quality assurance measures.

2. The Proposed Risk Adjustment Policy is Ill-Conceived.

On January 15, 1999, HCFA announced its methodology for implementing the risk adjustment mandate set forth in the BBA. While HIAA believes that improved risk adjustment is an appropriate and essential long-term goal for the program, we have serious concerns regarding the current HCFA proposal, which calls for the initial use of only inpatient hospital data. During the Administration's proposed 5-year phase-in period, plans would receive capitated payments based on a blend of payment amounts under the current demographic system and the interim (PIP-DCG) risk adjustment methodology. For the year 2000, for instance, the HCFA plan calls for a separate capitated payment rate for each enrollee based 90 percent on the demographic method and 10 percent on the risk adjustment methodology. By 2004, payment rates would be based on comprehensive risk adjustment using full (i.e., inpatient and other) encounter data and the demographic method would not be used. HIAA's concerns with this proposal are both practical and programmatic.

First, the practical. The time frame for implementation outlined by HCFA is simply far too short. Given the significant technological considerations involved, it is unreasonable for the agency to require that all Medicare+Choice organizations be able to provide physician, outpatient hospital, skilled nursing facility and home health data beginning as early as October 1, 1999. (HCFA has not yet identified a specific date by which this information must be provided, creating additional uncertainty.) The collection, verification, transmission and analysis of "representative" encounter data is a complicated endeavor. Capturing this data in a valid, accurate and transferable manner will be a major challenge for most plans. Indeed, some HIAA member companies that currently contract with HCFA do not have the technical capability to capture and transmit encounter data other than inpatient encounters. Nor do our members with PPO and similar network-style delivery systems have the capability to do so. They are simply not organized in a manner that will allow them to collect this level of data.

Even if the capital for such purposes can be arranged, HCFA's proposed time frame is insufficient to allow Medicare+Choice organizations to procure and install the required systems. Procuring systems that can accomplish these tasks requires very careful planning and assessment, review of the capabilities of competing technologies and vendors. Time is needed to install the systems, modify provider contracts if necessary to ensure adequate reporting to the Medicare+Choice plan, train the staff (both at the Medicare+Choice organization and provider locations) and verify and validate the data. All of these steps must be carefully executed or the system will fail. These obstacles to compliance cannot simply be wished away. Moreover, the imposition of these costs on all Medicare+Choice plans will make the development of rural plans even more difficult because they will continue to have fewer beneficiaries enrolled compared to plans in other areas.

The process by which information is communicated to, and received by, HCFA is likely to present significant technological problems as well, if past experience is any guide. HIAA members have experienced, and continue to experience, problems in ensuring that accurate inpatient hospital data is transmitted via Medicare fiscal intermediaries to HCFA.

Difficulties can also be expected as HCFA attempts to manipulate significant amounts of data for the first time using the proposed PIP-DCG risk adjustment model. The methodology developed by HCFA is complicated and requires numerous steps. The process is yet untested. HCFA faces a monumental task in getting the PIP-DCG system to work. We are awaiting the opportunity to review the plan-specific effects of the data collected to date. Moreover, as HCFA acknowledges, "the PIP-DCG model is [simply] an interim step towards implementation of a comprehensive risk adjustment model (i.e., one which uses diagnoses from all sites of service.)" HIAA strongly believes that the ambitious time frame proposed by the agency rests on a flawed premise: namely, that all of the anticipated technological and methodological problems can be resolved in the five-year window.

HIAA's doubts in this regard are heightened by the fact that planned implementation coincides, at least initially, with agency efforts to ensure Year 2000 readiness, both internally and in connection with Medicare+Choice organizations and other contractors. If HCFA transitions to risk adjustment before the necessary fixes are made and before reliable data are gathered and properly analyzed, the consequences could be catastrophic for individuals enrolled in Medicare+Choice plans, as well as the Medicare managed care program generally.

As if all this were not reason enough to delay implementation, HIAA has significant programmatic concerns regarding the proposed risk adjustment model. First, HIAA is concerned that variations resulting from excessive payments under the original Medicare fee-for-service program have been incorporated into the risk adjustment calculation. Additional, unnecessary hospitalizations that have occurred within the original Medicare Part A fee-for-service program, despite HCFA's attempt to fight this, are still significant. As a result, Medicare+Choice organizations will receive lower payments through the proposed risk adjustment methodology. HCFA should not penalize the managed care portion of Medicare for the program's failure to limit false or fraudulent claims and medically unnecessary hospitalizations. One approach to avoid this, would be to limit the use of risk adjustment so that the total amount paid to all Medicare+Choice plans is not reduced but instead redistributed among Medicare+Choice plans only.

Second, recognizing the fact that most federal agencies rely on sampling, HCFA's expectation of reported data on all individuals seems excessive. Given that even the more comprehensive risk adjuster will not be able to fully reflect all differences, HIAA believes that Congress should require HCFA to reexamine the use of plan-based sampling to reduce the administrative burden on the plans, reduce the potential for errors in the start-up phases, and increase the privacy of each individual's sensitive medical information.

Third, HIAA strongly believes that it is poor public policy to base risk adjustment—even temporarily—on inpatient hospital data only. Such an approach, even with the adjustments that HCFA has made to its initial risk adjustment proposal, would reward Medicare+Choice plans with excessive hospital use, and penalize plans that have effectively reduced inpatient hospitalizations and focused on providing more care on an outpatient basis. The incentives created by a risk adjustment methodology based exclusively on inpatient hospital data could result in increased inappropriate hospital use, increased avoidable costs, and a set back in the effort to realize greater efficiency in the health care system. Beneficiaries enrolled in plans with a relatively high proportion of members who receive care for expensive chronic illnesses outside the hospital setting would be particularly harmed.

For all these reasons, HIAA urges HCFA to delay the implementation date of risk adjustment beyond January 1, 2000. Since HCFA believes it does not have the authority to do this, Congress should revise the implementation date. While the effort to collect encounter data should proceed in a careful and deliberate manner, changes in payment methodology based on risk adjustment should not be implemented until complete and reliable encounter data are available. To ensure the validity of the data and a viable risk adjustment process, Congress should direct HCFA to (1) conduct a demonstration project aimed at validating the proposed methodology and (2) identify less costly and less data intensive ways of performing risk adjustment.

SUMMARY AND CONCLUSION

If the Medicare program is to be sustained for the next generation of beneficiaries and beyond, it is crucial that the federal government employ every strategy appro-

priate to enhance quality health care options for beneficiaries and encourage the development of lower cost options rather than relying on punitive regulations which will reduce choice and funnel more people into the highest cost option—fee-for-service Medicare. The Medicare+Choice program already is at an early crossroad where improvements can allow it to flourish but neglect of necessary change will doom it to failure. It would be more wise, in the long run, for the government to employ market-oriented strategies to ensure that there are Medicare+Choice options available to beneficiaries and to create incentives for private health insurers and providers to deliver value in the context of the Medicare program. Because it is a critical building block in this market-based strategy, Medicare+Choice must be successful.

In summary, HIAA believes that the prospects for success will be greatly improved if the following steps are taken with respect to the Medicare+Choice program:

- Adjust the payment structure so that increases cover medical inflation;
- Issue revised regulations to reduce costly administrative burdens on small, rural and non-HMO plans;
- Change the due date of ACRs to November 1 to eliminate unnecessary risk;
- Delay and revise the proposed risk adjustment model to reduce the cost of reporting and system development; and
- Modify the role of risk adjustment so that overall revenues to the Medicare+Choice program are not reduced, but simply reallocated among based on the health status of enrollees.

A final word of caution: Congress must act quickly to direct HCFA to change course in the manner outlined and to find ways to reduce the regulatory burden of participating in the Medicare+Choice program if it wants the program to succeed. The time frames for critical decisions relating, for instance, to system investments are very short, particularly given HCFA's anticipated risk adjustment schedule. Thus, if Congress is to make adjustments to the program, it should act now.

Thank you, Mr. Chairman. I would be happy to answer any questions you may have at this time.

Mr. BILIRAKIS. Thank you, Mr. Johnson. Thanks to all of you. Ms. Discenza, has Blue Cross/Blue Shield of Florida withdrawn from any county?

Ms. DISCENZA. No, sir, none at all.

Mr. BILIRAKIS. Why have you all chosen not to do it when so many others have?

Ms. DISCENZA. Our whole business is confined to Florida. And to ignore the seniors market in Florida would be a big mistake for us. We actually even have more customers under our Medigap products right now than we do under our Medicare+Choice. So we think that that market is one that we must value over the long term, but I will confess that we thought very seriously last fall.

Mr. BILIRAKIS. I was about to commend you. Go ahead, no.

Ms. DISCENZA. We did think very seriously about certain locations. Because honestly, not just the risk adjusters but the 2 percent cap with costs going up at 5 or 6 percent.

Mr. BILIRAKIS. Is that a bigger problem for you all, the 2 percent cap for that period of time versus the risk adjusters? You know risk adjustment is something, you heard the testimony earlier, is something that HCFA has been considering and working on for 10 years. And some of you say that you would like to see a year's delay. You know, it would be interesting to find out what an extra year would do when you have already been, it has already been worked on for a 10-year period of time?

I suppose there may be a little more out-patient information available and ambulatory-type information over a year's time. But let me ask you again, Ms. Discenza, I didn't mean to cut you off. Did you have something else?

Ms. DISCENZA. No, that is okay.

Mr. BILIRAKIS. Could you explain in a little more detail how payments to Medicare+Choice Plans have ended up being so far below the traditional fee-for-service program?

Ms. DISCENZA. In the initial part of the program, the 95 percent was chosen to recognize the fact that HMO's should have better overall experience, and when the Balanced Budget Amendment passed, that difference was widen. Widen because the reimbursement has been going up for all of our counties by 2 percent a year, when our costs are going up five or six.

Well that means that the 95 percent went to, say, 92 least year and to about 89 this year. Let us say to 86 or even 85 next year, and maybe combining that with the question that you asked a minute ago, risk adjusters or the reductions in overall payments, it is the combination of the two that really hurts us. That if we are already at 85 percent and the studies that I have read say that Medicare+Choice people have health improvements that average even 10 percent from the average population.

We are already pushed below that 10, and then to have the prospect of full risk adjuster implementation drive that down even further is, our concern is.

Mr. BILIRAKIS. Now Blue Cross/Blue Shield is a non-profit?

Ms. DISCENZA. We are a not-for-profit mutual that pays Federal income tax.

Mr. BILIRAKIS. I won't try to figure that one out.

Ms. DISCENZA. I won't either.

Mr. BILIRAKIS. Let me ask a question, I think you mentioned you wanted the opportunity to be able to work with HCFA in trying to devise a better, in your eyes, risk adjustment program. Well, let me ask the question. Have you been approached, have any of you been approached by HCFA? Do you have to work with HCFA?

Ms. MARGULIS. Yes.

Mr. BILIRAKIS. Okay. What has happened? Your advice has been ignored? Tell me a little bit.

Ms. MARGULIS. Mr. Chairman, we have been working with HCFA over a period of time on this payment methodology, and there are basically two issues, I will give two examples. The first is that while the loss specifies the use of in-patient hospital data and such other data as the Secretary requires.

Mr. BILIRAKIS. And we recognize that that is really not the best way to approach it.

Ms. MARGULIS. Correct. But HCFA had the opportunity along the way, as we shared our information with them, to make some different choices that would not have created as large a bias against the managed care plans. And I would list a couple of those for you. The first is, I believe, Mr. Bertko referred to short stays. As you may be aware, managed care plans have significantly more 1-day stays. That is probably due to the fact that we treat our beneficiaries in an out-patient setting and into these management programs.

Second, by using in-patient hospital data, it does not recognize those other in-patient settings, such as skilled-nursing facilities, where we may take someone with a diagnosis who has been in the hospital for 1 day and transfer them to a skilled-nursing facility. We have that data, we could have provided that data to HCFA.

Third, with regard to those conditions that could be treated on an in-patient or out-patient basis, while HCFA did make some inroads in agreeing that those could be considered discretionary conditions, there is some others, for example, in the chronic heart failure area that are still left in that bias against us.

So we have worked with them. The second area, if I might talk about that is, for months we have asked HCFA to supply us with the data necessary to replicate the formulas to be able, as Mr. Bertko said, to go back and recalculate the formulas and the information that HCFA has. They have not supplied us with that information. Sorry for the long answer. I probably could go on.

Mr. BILIRAKIS. Well, I think, again, I think it was you who talked about disease management programs. You make a good point in that regard. Certainly the Y2K is something that maybe we haven't considered adequately. I have, after Mr. Brown finishes up, I am sure Humana is anticipating a question from a Floridian.

Ms. MARGULIS. Absolutely.

Mr. BILIRAKIS. Mr. Brown.

Mr. BROWN. There seems to be a lot of Floridians on this panel. Is that my imagination?

Mr. BILIRAKIS. Ms. Margulis is from Louisville, Kentucky, by the way.

Mr. BROWN. Yeah, but there is still one. Thank you. Mr. Chairman, I am a little perplexed by all this. You know I represent a district in northeast Ohio. Two counties in my district United Health Care disenrolled 2,000 people in each county. Gave sort of cavalier notice to them by publishing something in the newspaper.

Then I read in the paper that the CEO of United Health Care made $68 million last year. I read in the Los Angeles Times, Orange County edition, the county where Mr. Schub's company is, I think. PacifiCare Health Systems, No. 1 operator of Medicare HMO said fourth quarter operating profits more than tripled as it left some markets and cut costs. You see executive salaries skyrocketing in this business.

You see huge marketing costs with full page ads in expensive big city newspapers. Then I read that more and more of you are dropping senior citizens in some counties, because you are just not getting enough money to cover them. But in counties next door you are staying because beneficiaries there are profitable. And then Mr. Schub's testimony says, unless Congress takes corrective action, the number of providers who refuse to contract with Medicare+Choice plans will increase and health plan withdrawals will continue at a more rapid pace. All within the context of bigger executive salaries, good profits for PacifiCare, expensive marketing campaigns. And you want the Medicare Commission to give you more money. That's what I don't understand, Mr. Schub.

Mr. SCHUB. I think maybe I would start, Mr. Brown, with just a comment that the industry has been going through a lot of change through the preceding years. In that period of change, health plans have been profitable and unprofitable, and our company as well. Last year we had some significant write downs from markets that were, were literally out of control.

So the news release you saw was a company that has gotten itself to a little more than 2 percent after tax profit margin, with

a lot of hard work and see ourselves as a stable company right now. We are committed to the Medicare business. We take our seniors to be our No. 1 priority. The health improvement our seniors and the success of our provider partners is what our company is about.

We have to earn more than, we have to have some retained earnings to be able to apply capital and expand the program. We believe that a slightly more than 2 percent after tax margin, is an acceptable margin when you consider the fact that any not-for-profit hospital has to maintain at least twice that to simply maintain their bond rating and borrow money. So all organizations in health care have to have some sort of a margin after tax.

As it relates to executive compensation, we bench mark ourselves against other industries. I can't speak for United, but I know that within PacifiCare we bench mark ourselves against other industries and are not excessive in terms of executive compensation. To the point, last year there were no bonuses paid, simply because of the fact that the company did not perform.

Mr. BROWN. Mr. Bertko, you mentioned in your testimony that HCFA's proposed risk adjustment model is an improvement over the status quo. You said payments to health plans would be more accurate. Tell us some of the deficiencies in the current AAPCC rate, if you would?

Mr. BERTKO. Yes, I will. First off, I think many of the previous speakers have said that in general the age, gender and status ones basically overpay for folks that are very healthy and do underpay by some considerable amount for folks who are in the sickest quartile or quintile. So that is the main feeling of it. It doesn't recognize the real needs of the population. And in this case, by using this part of diagnostic data, you are able to better match, not perfectly, but better match up what the payment would be versus what the needs of the population are.

Mr. BROWN. So risk adjustment clearly is preferable to AAPCC, I mean there is no doubt about that?

Mr. BERTKO. Yes. And again, I think the only thing I would add there is that the data streams and the mechanics that go with it have to be in the right shape when you start it up.

Mr. BROWN. I have one other question. Ms. Discenza, HCFA says that managed care plans are experiencing favorable selection. Most managed cares plans disagree with that notion. If HCFA says that many of you are experiencing favorable selection and many of you disagree with that statement, does that mean that you have better data or tools than HCFA does to assess beneficiaries' health status?

Ms. DISCENZA. Actually the studies that I have seen I don't think the majority of us would question that in fact people who choose to join HMO's usually have had better past health care results than people who choose not to join HMO's. That is true not in just the seniors' market but in the under 65 market as well. That is something though that tends to happen more often when a program is new than when it is very mature.

If we look at, for example, the under 65 population today with as broad an HMO enrollment as there is today, there is not, the gap between those who will choose an HMO and those who don't is narrowing. I personally do not question at all the studies that

show that those who join, the seniors who join an HMO were easily in 10 percent, 5 to 10 percent better health in the year before the joined.

Mr. BROWN. So that would, that would certainly argue for a risk adjustment?

Ms. DISCENZA. There is no question that risk adjusters, done correctly, are appropriate.

Mr. BILIRAKIS. So what you are saying is that risk adjustment can be beneficial as well as the opposite for your company, right?

Ms. DISCENZA. Risk adjusters, done appropriately.

Mr. BILIRAKIS. Done correctly.

Ms. DISCENZA. The problem is that if we started off, as I mentioned earlier, with 95 percent with a 5-percent reduction in the beginning of the Medicare, what was called Medicare Risk Program, that has now moved down to below 90. And if we move with risk adjusters down from there, it seems to me we could well be double counting this purported healthiness of the Medicare+Choice enrollment.

Mr. BILIRAKIS. Mr. Bryant, would you like to inquire?

Mr. BRYANT. Thank you, Mr. Chairman. I will ask maybe one or two of you if you want to answer this. Many health plans have developed specialized programs and provide high quality care in settings other than hospitals to members who otherwise would have been treated as an in-patient setting. Can you provide an example of such a program that you have and how it is penalized by HCFA's new risk adjustment method? And I have got a CNA question.

Ms. MARGULIS. Mr. Bryant, we have a congestive heart failure program that covers approximately 4,000 beneficiaries in our market. We anticipate this next year that we will be able to reduce hospital admissions by 2,300 of those beneficiaries. Each one of those avoided hospitalizations is $12,000, which will result in a potential $28 million loss. And if I put that on a per beneficiary basis, that could mean that we would have to reduce prescription drug coverage in those markets for beneficiaries.

Mr. BRYANT. Did you get any comfort this morning from Mr. Hash. I think, I thought I heard him say that they were going to try to use other provider, medical encounters fairly soon. Although I understood it was going to be 3 or 4 years, 5 years perhaps. But I thought I heard him say that that was going to be more immediate.

Ms. MARGULIS. No sir, unless we have some sort of delay where we can go back and perhaps make some adjustments, test the data. A page from the California HPIC would be to step back, make sure that we can accurately correct and process the data and simulate the payment method so that we can make corrections.

What I would say too, and I have heard a lot people here today say this. We are talking about implementing a risk adjustment system done correctly. But I would say to the members of the committee, this is now being done on top of a pile of other reductions that has already, in essence, taken away any favorable selection that there would have been.

So we are very cognizant of that and concerned that we won't be able to offer the kinds of additional benefits that attract people to our programs. If we don't go back and correct some of the errors

and flaws that we think this current process has. And to implement, as many of the Panelists spoke about, we are only implementing 10 percent of this new payment methodology. We think it is wrong to implement a flawed system. It means the second year is only, the problems are only exacerbated.

Mr. BRYANT. You know, what I hear you saying is that while the rhetoric is there that they want competition in private sector market place to work, the regulations and the implementation is making it, these items are making it very difficult for you to compete and operate. Would that be a yes or no?

Mr. JOHNSON. It would be a yes. A large part of it is the uncertainty, a And the anxiety, particularly for providers, who are going at risk. In a fee-for-service world, the risk is minimal and you can control some of that by working harder, doing more procedures, whatever. In a capitated world where you are really trying to be organized, coordinating care and take all comers. Most of the provider plans we represent are not-for-profits who are doing this in the community because there is an access issue.

For those continued uncertainty about how the regulations are going to hit them next year or in 6 months, without the flexibility to adapt, is just causing them to say, no, let us not do it. And on balance, these systems offer improvements. At least they offer a different kind of care and a choice. Which really ought to be in the system, but for providers it is not, they are not going to do it.

It is just the regulatory system, the uncertainly about how these adjustments are going to affect them, a And risk adjustments should help providers. We will attract a disproportionate number of sick patients if we have a good reputation in our community. But we don't know whether being efficient about it, reducing in-patient stays, is going to actually hurt us or help us in the formula. And we don't know whether we can get all the data together to actually produce what is needed by HCFA in the timeframe required.

Mr. BRYANT. Mr. Schub.

Mr. SCHUB. If I could just add to that, thank you Mr. Bryant. The point that was raised before by the chairman, that predictability is a big issue, a And the simplicity of understanding, you can't serve two masters. And that is what the comments that were just made refer to. That physicians, they generally practice one style of medicine and they need to know what the game is and what you want them to do. And they can demonstrate significant changes in health care cost reductions while maintaining quality and satisfaction. But at this point, they are getting very confused.

Mr. BILIRAKIS. Well thanks, Mr. Bryant. Just one comment here. For instance, Humana, I don't mean to pick on you but I have already told you——

Ms. MARGULIS. It has been done before.

Mr. BILIRAKIS. Humana has pulled out or reduced services in 14 Florida counties. That plan pulled out or reduced services more than any other plan in our State. None of that took place in my Congressional District, I suppose that was more of a coincidence than anything else. But you know, your timing, not only Humana's but I think managed care's timing stinks, quite frankly. I mean you are under attack these days. I don't think a 2-percent profit margin in wrong.

This is America. If the stockholders of United, is it, don't care about their CEO receiving a $65 million salary last year, then I am not going to care about it. But if in fact I see that that company has pulled out and really putting in jeopardy a lot of Medicare beneficiaries, then that is going to concern me. You have said you will work with HCFA. You have said that HCFA has been respondent in some degrees and not respondent in others.

I don't know. Are you going to basically force us to do what most of us don't want to do? And that is to mandate that you continue to cover some of these Medicare beneficiaries in some of our, well, in America? You could be leading toward that. And I don't think you want that. And I guarantee you I don't want that. But you know, we have got people out there who have complained to us. Now maybe some of them would, some of these plans would have withdrawn anyhow in the normal course of events.

But as I said, your timing is rotten and it seems to me that, you know, I get the feeling that you are using this risk adjustment as rationale. And you are using it, basically I made the comment in my opening statement about on the come. Risk adjustment is coming and you are not happy with the way it seems to be devised by HCFA. You are pulling out and you feel that maybe that is going to be beneficial to work with HCFA to improve it.

But it may work the other way around. And I would really hate to see that, but it could happen. Do you have any comment, Ms. Margulis? I guess I should at least give you that opportunity.

Ms. MARGULIS. Yes sir. Yes, we also, I might say, thought the timing was very poor as well. Let me say first that we have been in the Medicare Risk and now Medicare+Choice Program for 13 years.

Mr. BILIRAKIS. Any you are heavy in the Tampa Bay area in Florida.

Ms. MARGULIS. Clearly, clearly. And we bought a troubled, you may remember, plan back in 1987.

Mr. BILIRAKIS. I remember.

Ms. MARGULIS. And had troubles for many years.

Mr. BILIRAKIS. And that is why I say, I don't know that. I should question a 2-percent return or whatever the case may be. I don't do that.

Ms. MARGULIS. I think what I would want to say to you is that we have been a long, long-term participant in this program. We believe in it. We would like to be in every Florida county. The situation last year was unusual for us. You may recall last year we acquired a large company in Florida, Physician Corporation of America. There were issues in some of those counties that were related to an acquisition and integration. One of the requirements for us to remain in this program is to have adequate provider health care delivery systems and adequate networks, a And in many cases we were unable to have that kind of network that we could offer an affordable, quality product.

Mr. BILIRAKIS. Why, because of the current, because of the current AAPCC or what? What was the reason?

Ms. MARGULIS. Related to a variety of considerations, a And I believe Mr. Hash and several people said that withdrawals are due to many conditions in a market. Let me say this, that the promul-

gation of the Medicare+Choice rules, the timing of that plus the notification deadline for non-renewals and the thought that if we could change the environmental situation in many of those counties in 1999 or 2000, we could go back to those counties.

I think a number of our decisions were based on that.

Mr. BILIRAKIS. I am sorry, what do you mean by environmental?

Ms. MARGULIS. If, when pulling out in October, there is no 5 year penalty for going back, s So we would have an opportunity, if we could build an adequate network and realize that we would be able to cover our costs for providing services that would attract beneficiaries to our plans, we could go back. I think what I want to say long term is that it is our intent to be a long-time participant in this program.

We want to work on, not only a payment methodology that doesn't every year put Congress in the position of having a formula fight, b But also one that can deliver additional benefits to seniors and to all beneficiaries to join this program. The risk adjustment methodology we feel, if implemented correctly and based on adequate and sufficient data, will help. As I mentioned before, not on top of a whole lot of other payment reductions so that we can no longer be attractive to people in the fee-for-service sector to select us.

Mr. BILIRAKIS. Well, all right. I want to publicly commend HCFA, gentleman, there may be more than just you here, sir, I don't know. But the point is I have asked that they have a representative here to listen to all this, they have, and I think that is good. But you have also heard that there might be openness for more work with these people. As much as we may try, the risk adjustment seems to be something that everybody thinks is a good idea, but you say it has to be done right.

I don't know what doing it right is or isn't. But you know we have beneficiaries out there who have lost a choice, a very important choice. And we have to respond to them.

And I think you all have got to realize that. Hopefully you do. I have nothing further. Do you have anything further, Mr. Brown? Well, thank you so very much. Again, I appreciate your patience.

[Whereupon, at 2:16 p.m., the subcommittee was adjourned.]